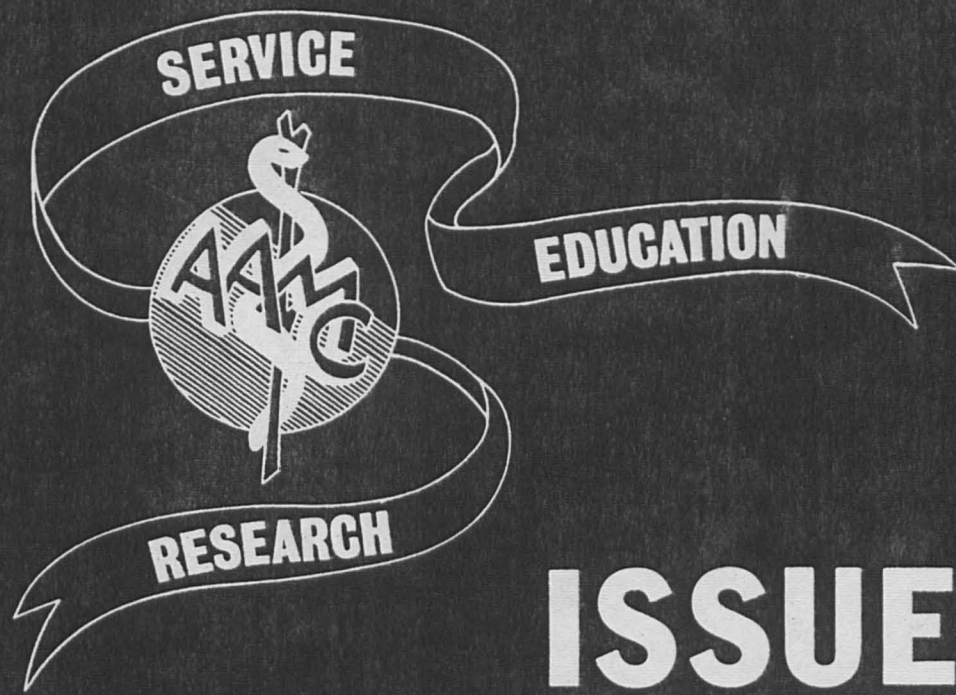


Sept 1974 - June 1975 Position Statements (Item 80): Issues, Policies, Programs of the AAMC

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ISSUES POLICIES PROGRAMS

**OF THE
ASSOCIATION OF
AMERICAN MEDICAL COLLEGES**

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

FOUNDED 1876

"The Association of American Medical Colleges has as its purpose the advancement of medical education and the Nation's health. In pursuing this purpose, the Association works with many national and international organizations, institutions, and individuals interested in strengthening the quality of medical education at all levels, the search for biomedical knowledge, and the application of these tools to providing effective health care.

As an educational association representative of members having similar purposes, the primary role of the AAMC is to assist those members by providing services at the national level which will facilitate the accomplishment of their mission. Such activities may include collecting data and conducting studies on issues of major concern, evaluating the quality of educational programs through the accreditation process, providing consultation and technical assistance to institutions as needs are identified, synthesizing the opinions of an informed membership for consideration at the national level, and improving communication among those concerned with medical education and the Nation's health. Other activities of the Association reflect the expressed concerns and priorities of the officers and governing bodies."

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F O R E W O R D

This publication, developed by the staff of the Association of American Medical Colleges, presents:

1. The major issues which the Association faces as the national representative of United States medical schools and teaching hospitals;
2. The Association's current policy or steps to develop policy on each particular issue; and
3. AAMC activities undertaken in an effort to achieve the goals related to those policies.

In accordance with a directive from the Association's Executive Council, this document has been distributed to the constituent members of the Association. It will be updated periodically; pages reflecting new policy issues and revisions of existing ones will be distributed, as necessary.

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ISSUE: HOW AND BY WHOM SHOULD ACCEPTABLE QUALITATIVE LEVELS OF EDUCATIONAL PROGRAMS BE ASSURED?

PRESENT STATE OF POLICY DEVELOPMENT:

The primary responsibility for assuring that educational programs are of acceptable quality rests with each institution. It is a responsibility borne primarily by its faculty exercising its collective academic judgment in the design and implementation of the curriculum, the assignment of competent educators, the selection of capable students and the evaluation of their performance. The institution is assisted in gauging its own performance through the availability of external assessment procedures and instruments.

Accreditation of institutions and education programs is the primary instrument developed by the institutions and the professions as a means of external review, monitoring and assessment of the institutional or program quality. As it has evolved, accreditation brings to bear the disinterested expert judgment of outside professionals and academicians, leavened by the perspective of informed public representatives. Its purpose is to assure the institution that its resources are adequate to serve its objectives and directed toward their achievement, to assure applicants and students that their education can be successfully pursued in the institution, and to assure society that its resources are appropriately utilized and the graduates of the institution are qualified according to their credentials.

The AAMC Assembly approved the revised *Function and Structure of a Medical School* in 1972, setting forth the criteria to be used in the accreditation of medical schools.

PROGRESS TOWARD ACCOMPLISHMENT:

Two parallel efforts are underway to achieve the purposes and objectives of accreditation as a guarantor of educational program quality. The first is directed toward refining the sophistication of the process of accreditation; it involves the development of more appropriate organizational forms — the formation of the CCME, the LCGME and progress toward an LCCME to complement the role and function of the LCME — the refinement of the accreditation standards — the *Function and Structure of a Medical School*, the *Criteria for Programs in the Basic Medical Sciences* — the development of more appropriate assessment procedures and instruments — the exploration of the use of the self study protocol, the refinement of data collection instruments.

The second involves defending the integrity of voluntary accreditation from encroachment and dismantlement by the Federal government and zealous critics of the system. This has entailed a review, critique and negotiations for revisions in the OE draft Criteria for Recognized Accrediting Agencies, comments on the SASHEP Report, review and comment on the Newman Report, "National Policy and Higher Education," and the Brookings Institution (Orlans) report, "Private Accreditation and Public Eligibility."

AAMC DEPARTMENT PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE: LCME, LCGME, CCME (AAMC participates in these conjoint committees)

ISSUE: SHOULD SOCIAL POLICY AND ETHICAL CONCERNS OF SOCIETY BE ENFORCED THROUGH THE ACCREDITATION PROCESS?

PRESENT STATE OF POLICY DEVELOPMENT:

Ethical concerns are an integral part of any professional education program; ethical standards are inculcated through precept and example. To the extent that institutional behavior impinges upon the quality of an educational program, it is a matter of legitimate and appropriate concern of the accrediting body and process. On the other hand, it is the policy of the AAMC, supported and implemented by the LCME, that other more appropriate means are available to assure compliance with public policy and that any effort which would subvert the purpose of accreditation to the implementation of societal goals other than the assurance of program quality – no matter how laudatory – should be vigorously opposed. While it is clear that the standards, policies and procedures for accreditation cannot conflict with, or subvert, public policy aspirations expressed in law, whether statutory or judicially established, it should be equally clear that accreditation cannot bear the burden of a requirement that it be a catch-all instrument of enforcement with respect to academic institutions. Its mission in society is the assessment of the quality of education and training programs.

PROGRESS TOWARD ACCOMPLISHMENT:

The work of the LCME is carried on against the background of this policy with an acute sensitivity and awareness as to what extent ethical practices impinge upon the quality of education. This policy is constantly being tested in day to day operation. Legitimate ethical concerns for accrediting bodies are, for example, those which delineate the organization, responsibilities and privileges for the administration, faculty and students that there be no discrimination in admissions or employment on the basis of sex, creed, race or national origin. Institutional practices regarding human experimentation and animal care facilities illustrate two other types of ethical considerations which can impinge on the quality of the educational program.

The question raised by the issue set forth above is directed toward the use of the denial of accreditation as an enforcement instrument of social policy. This explanation of progress reflects the kinds of issues which confront the accrediting agency on a continuing basis as it proceeds to guarantee an acceptable level of quality in medical education as a public responsibility.

Outside the context of accreditation the AAMC can and is directing considerable effort to assisting its constituency in such areas as minority students, affirmative action, human experimentation, etc. If an institution has impeccable practices and procedures carefully observed, these matters will cease to receive undue attention in the accreditation arena.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE: LCME, CCME, LCGME, (AAMC participates in these conjoint committees)

ISSUE: SHOULD THERE BE A NATIONAL EXAMINATION REQUIRED FOR ALL STUDENTS AT THE INTER-FACE BETWEEN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION?

Entrance into graduate medical education for U.S. medical students has only required the satisfactory completion of a course of study and the awarding of an M.D. degree by an accredited medical school. Although some graduate medical institutions and some states have required that residents be licensed and thus have required the passing of a licensing exam such as the NBME exam, the FLEX exam or state licensing board exam, there has been no uniform, national requirement for all students who enter graduate medical education to pass a qualifying exam.

PRESENT STATE OF POLICY DEVELOPMENT:

The Executive Council approved the report of the Task Force on Foreign Medical Graduates which recommends "... that a generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the National Board Examination or the FLEX examination should be required."

The National Board of Medical Examiners established a Committee on Goals and Priorities in 1971. The Committee report entitled, "Evaluation in the Continuum of Medical Education," was released in June 1973. This report recommends the development of a qualifying exam required for all who enter graduate medical education in the United States whether they have received their M.D. degree from a domestic or foreign school. This report was received by the NBME and has been under intense study during the subsequent 10 months. The NBME does not plan immediate implementation.

The Executive Council established a Task Force to analyze the Goals and Priorities Committee report and recommend to the Executive Council a position on this issue.

PROGRESS TOWARD ACCOMPLISHMENT:

The FMG Task Force report was distributed to the constituency for reaction and comments.

The Task Force on the GAP Report reported to the Executive Council in the Fall of 1974. Among a number of specific recommendations to the AAMC was included an endorsement of the concept of a qualifying examination required for all who enter graduate medical education in the United States. The report of the Task Force is currently under review by the Organization of Student Representatives and the three Councils prior to final Executive Council consideration.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs; Department of Institutional Development; Division of International Medical Education

AAMC COMMITTEE: FMG Task Force – discharged; Ad Hoc Task Force on the NBME-GAP Report; CCME

ISSUE: SHOULD THE AAMC ASSIST MEDICAL SCHOOL FACULTIES IN IMPROVING THEIR CAPACITIES TO MEET THEIR GROWING EDUCATIONAL COMMITMENTS?

This is a time when faculty members in our medical schools are being called upon to educate increasing numbers of students, without comparably increased numbers of faculty or enlarged resources, while assuring that there is, at the very least, no decrease in the quality of the educational product. At the same time, it is being increasingly recognized that although instruction is the primary responsibility of medical school faculty members, it is the responsibility for which they are least prepared.

PRESENT STATE OF POLICY DEVELOPMENT:

Until the present, the AAMC has done little, if anything, in the area of direct assistance to faculty in the improvement of their capacity as instructors. In March 1974, the decision was made to establish a new Division of Faculty Development, which began to function on September 1, 1974. It is the responsibility of this Division to devise methods and develop services which will assist faculty members of medical schools in improving their effectiveness as teachers, and in the efficient use of their instructional time.

PROGRESS TOWARD ACCOMPLISHMENT:

The Division's first project will be the design of materials and methods to enable faculty members to undertake a confidential self-assessment of their effectiveness as instructors. Pilot testing of preliminary materials is expected to begin in late 1975. Subsequent activities will include the offering of workshops and seminars, and the development of a clearinghouse on information about instructional improvement.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Faculty Development

AAMC COMMITTEE:

ISSUE: SHOULD THE AAMC PLAY AN ACTIVE ROLE IN IMPROVING THE ACCESSIBILITY AND EFFECTIVE USE OF MULTI-MEDIA EDUCATIONAL RESOURCES?

The increasing development of educational technologies has provided an ever increasing universe of multi-media learning materials to assist medical school faculties in their teaching of increasing numbers of students. These same technologies have provided students with an opportunity to better realize a more individualized medical curriculum and to enhance the development of their skills in self-education, self-evaluation and communication. Problems relating to the use of multi-media educational material include: the absence of an efficient clearinghouse for evaluated materials; the availability and shareability of these materials by institutions and subject areas of perceived need; the varying abilities of faculties and students to utilize these materials effectively and the irregular patterns of quality and cost.

PRESENT STATE OF POLICY DEVELOPMENT:

A series of recommendations was presented to both the NLM and the academic community defining the roles and responsibilities of both the academic community and the Federal government in enhancing the uses of educational technology in medical education. Reports were published as supplements to the *Journal of Medical Education*, Vol. 46: July (Part 2), 1971; and Vol. 48:203-226, No. 2, February 1973.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC Division of Educational Resources was established in 1973. A contract from NLM permitted the initiation of the AAMC/AADS Educational Materials Project. The five basic programs include: the development of a system for the appraisal of educational materials in nontraditional formats (audiovisual, computer-based instruction, simulations, etc.); the development and implementation of a clearinghouse system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by students and faculties; and other areas of mutual concern regarding the uses of educational technology in health science education. During the latter part of 1974 the Lister Hill Center for Biomedical Communications (NLM) requested the continuation of the collaborative effort between the AAMC and the NLM regarding the use of computer-based educational materials in medicine. Areas of mutual concern under discussion include problems related to the creation, review, sharing and distribution of computer-based educational materials as well as the need for an extensive program in educating the constituency regarding the costs, effective use and acceptance of this form of instruction. A grant from the Kaiser Family Foundation and Commonwealth Fund has permitted a feasibility study to explore the development of a national institutional model to enhance the use and effectiveness of multimedia learning systems. The Association intends to explore the availability of resources for support of the proposed program from foundations and agencies interested in advancing the health sciences education through multimedia. The implementation of the program will depend upon the outcome of this assessment.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Educational Resources

AAMC COMMITTEE: AAMC/AADS Educational Materials Project Advisory; Kaiser/Commonwealth Feasibility Study Advisory Panel

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ISSUE: SHOULD CLINICAL EDUCATIONAL PROGRAMS IN DIVERSIFIED SETTINGS BE ENCOURAGED?

The ambulatory care function of the academic medical center takes place in a variety of settings, the most universal of which are outpatient departments and emergency services. Others include neighborhood health centers, C and Y clinics, group practices and HMO's. Settings in which quality primary care is delivered are considered to be appropriate sites for primary care training programs. To meet the increased need for appropriate primary care, academic medical center faculty involved in the delivery of primary care must integrate ambulatory service and teaching into effective training programs.

PRESENT STATE OF POLICY DEVELOPMENT:

The Functions and Structure of a Medical School, prepared by the LCME and ratified by the Assembly in November 1972, states, "Instruction should be sufficiently comprehensive so as to include the study of both mental and physical disease in patients who are hospitalized as well as *ambulatory*."

AAMC testimony on area health education centers, health maintenance organizations and health manpower legislation has requested support for the development of physician training programs in a variety of organizational frameworks and different health care facilities.

PROGRESS TOWARD ACCOMPLISHMENT:

A survey of the schools in 1973 revealed that undergraduate students have on the average only 2 months of clinical experience in ambulatory settings. Beginning May 1, 1974, through a contract with the Bureau of Health Resources Development, a pilot program to develop physician training programs in HMO's was begun in the Spring of 1974.

A primary care institute, held in October 1974, and attended by deans and chairmen of medicine, pediatrics, family medicine, and others, focussed on the organization of optimum settings for primary care training programs. AAMC sponsored regional workshops addressing these issues in more detail convened during the Spring of 1975.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Task Force on Primary Care

ISSUE: TO WHAT EXTENT SHOULD QUALITY OF CARE ASSURANCE PROGRAMS BE INTEGRATED INTO CLINICAL EDUCATION?

Inasmuch as quality of care should be a major concern of practicing physicians, there is a need in academic medical centers to involve medical students and house staff in medical care evaluation programs during their training period. These programs in quality assessment and assurance should take place within both the didactic and clinical portions of the curriculum, and should prepare students to accept peer review of their professional activities with equanimity.

PRESENT STATE OF POLICY DEVELOPMENT:

In March of 1973, the Executive Council approved 5 propositions on which to base a new thrust in continuing education. The first of these states, "The medical faculty has responsibility to impress upon students that the process of self-education is continuous and *that they are going to be expected to demonstrate that they are competent to deliver care to patients through-out their professional lives.*"

At the same meeting the Executive Council approved and adopted the following statement:

"The AAMC believes that the development and implementation of norms and standards for assessing the quality of health care is a vital responsibility of the medical school faculty and organized staff of the teaching hospital. A major part of this responsibility is the incorporation of quality-of-care assessment into clinical educational programs to develop in medical students and residents a life-long concern for quality in their practice."

PROGRESS TOWARD ACCOMPLISHMENT:

At the Annual Meeting in 1972, presentations were made to the Councils regarding the potential impact of the PSRO amendment in the Social Security Amendments of 1972. The desirability of having academic medical centers become engaged in quality of care assurance programs and integration of these programs into their educational system was emphasized. There has been no organized plan to proceed with these efforts.

The AAMC is presently exploring the feasibility of contracting with the DHEW to develop models for integrating evaluation into medical school curricula.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee/ Subcommittee on Quality of Care

ISSUE: HOW CAN MEDICAL SCHOOLS OFFER EDUCATIONAL OPPORTUNITIES IN INTERNATIONAL HEALTH?

There is widespread interest among medical students in international health, but only a few medical schools are in a position to offer instruction and field experience in this area.

PRESENT STATE OF POLICY DEVELOPMENT:

With guidance from the Committee on International Relations in Medical Education and the Liaison Officers for International Activities, the Division of International Medical Education has developed a document entitled "Essentials for Programs of Education in International Health." This document proposes a sequence of three different kinds of elective opportunities in the international or cross-cultural health field. They are: (1) an introductory course; (2) a practicum; (3) a residency program.

PROGRESS TOWARD ACCOMPLISHMENT:

A special advisory committee and a contract from the Fogarty International Center have assisted AAMC in developing an outline for a self-instructional course as an "Introduction to International Health" eventually to be made available to medical and other health professions students.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of International Medical Education.

AAMC COMMITTEE: Committee on International Relations in Medical Education and International Program Advisory Committee.

ISSUE: SHOULD THE MEDICAL SCHOOLS ASSUME INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS OF GRADUATE MEDICAL EDUCATION?

The medical schools have increasingly become engaged with graduate medical education, and most schools have as many or more interns or residents as they have undergraduate medical students. However, the responsibility and authority for these programs is divided among the many department heads in the clinical disciplines and is further divided among the several hospitals which make up most academic medical centers. The issue revolves around having the academic medical centers develop systems which make the entire faculty responsible for graduate medical education and provide for overall administration of graduate programs by the academic medical centers' administrative teams. The dean of the medical school would thus have a far greater role in planning and developing graduate programs for residents.

PRESENT STATE OF POLICY DEVELOPMENT:

By action of the Assembly in 1971, a position statement (published in *AAMC Bulletin*, Nov. 15, 1971) recommends that the academic medical centers assume responsibility for graduate medical education in a fashion analogous to that for which they have responsibility for undergraduate medical education. This implies that the faculty of the institutions as a whole should assume responsibility for planning and evaluating the graduate programs of instruction and should set the standards for student selection, progress and certification for readiness to be examined by specialty boards. The program further recommends that freestanding hospitals desiring to continue or develop graduate medical education programs should seek affiliation with university academic centers or should develop sufficient resources to permit their being accredited as freestanding graduate medical schools. This position statement was evolved subsequent to a conference of the Council of Academic Societies in 1968; the proceedings were published as a special issue of the *Journal of Medical Education (J. Med. Educ., Vol. 44: September (Special Issue) 1969)*. A committee chaired by Thomas D. Kinney published the IMPLICATIONS document (*J. Med. Educ., Vol. 47: 77-84, No. 2, February 1972*).

PROGRESS TOWARD ACCOMPLISHMENT:

The Graduate Medical Education Committee, chaired by William G. Anlyan published a supplement to the *Journal of Medical Education*, entitled "Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education" (*J. Med. Educ., Vol. 48: 780-791, No. 8, August 1973*). According to a 1974 AAMC survey of academic medical centers, out of 103 respondents 72 reported that the centers have considered the assumption of institutional responsibility for graduate medical education. Thirty of the 72 have definite plans to proceed with the concept, and another 32 centers reported that positive action in this direction is probable. Data from the survey have been summarized for publication (Datagram, *J. Med. Educ., Vol. 50: No. 4, April 1975*). The CCME has adopted a statement which incorporated the principal recommendations of the AAMC position statement; the Executive Council ratified the CCME statement.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs; Division of Student Studies

AAMC COMMITTEE: Graduate Medical Education Committee

ISSUE: SHOULD ACCREDITATION OR OTHER EXTERNAL MECHANISMS BE USED TO REGULATE THE NUMBER AND DISTRIBUTION OF RESIDENCY POSITIONS?

Residency and fellowship positions in the specialties and subspecialties have never been subject to quantitative controls. The number of programs currently existing is a result of multiple independent decisions by hospitals and program directors. The Boards and the Residency Review Committees have no policies relating to the number of specialty programs in the United States.

PRESENT STATE OF POLICY DEVELOPMENT:

One of the implications of the institutional responsibility statement is that the institutions should assume responsibility for determining both the types of residency and fellowship programs they will sponsor and the number of students they will enroll. The Graduate Medical Education Committee recommended in its informational report to the Executive Council in December 1973 that the schools and graduate programs should set a goal of enrolling and retaining 50% of graduating medical students in the primary care specialties of family medicine, general medicine and general pediatrics. The issue of using the accreditation mechanism for limiting the number of graduate programs has been discussed informally at several levels, including the CCME's *Ad Hoc* Committee on Physician Distribution.

In March 1974, the Executive Council approved the FMG Task Force Report which recommended "... that the number of first year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools, but provide sufficient opportunities to highly qualified FMG's "

PROGRESS TOWARD ACCOMPLISHMENT:

The Ad Hoc Task Force which was appointed to revise the Association position on the Federal role in health professions educational assistance recommended to the Executive Council that the Association support the concept that the Secretary of HEW be empowered to determine the total number of residency positions to be occupied, the distribution of these positions among specialty programs and the number of first-year positions to be made available each year. The Secretary will be required to designate either the Coordinating Council on Medical Education or an alternative agency with membership nominated by the parent organizations of the CCME and including public representatives, a resident and osteopathic representatives as the advisory body for determining the distribution of residency positions. Residency program accreditation will be the responsibility of the Liaison Committee on Graduate Medical Education. The LCGME will base accreditation on educational quality of programs and will not consider manpower needs in reaching its decisions. This recommendation was accepted by the Executive Council in January of 1975 and has been introduced into the legislation for renewal of the Comprehensive Health Manpower Training Act.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs;
Department of Institutional Development

AAMC COMMITTEE: LCGME, CCME (AAMC participates in these conjoint committees)

ISSUE: HOW SHOULD GRADUATES OF FOREIGN MEDICAL SCHOOLS BE INTEGRATED INTO UNITED STATES PROGRAMS OF GRADUATE MEDICAL EDUCATION AND INTO THE UNITED STATES HEALTH CARE SYSTEM?

In 1972 one third of all enrolled interns and residents in United States teaching hospitals and 49 percent of all physicians receiving state licenses to practice medicine were graduates of foreign medical schools. This disproportionate representation of FMG's represents a threat to quality education and services.

PRESENT STATE OF POLICY DEVELOPMENT:

The FMG Task Force of the AAMC in a report approved by the Executive Council made the following policy recommendations:

1. A generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the National Board Examination or the FLEX Examination should be required.
2. Pilot programs with enrolled FMG's should explore their educational defects and ways to correct them.
3. The approval of hospital programs for graduate medical education should be based on sound educational principles and the number of positions available should not exceed to any great extent the number of graduates from United States medical schools.
4. The permanent employment of unqualified, unlicensed FMG's should be discontinued even in the institutional setting.
5. Pilot programs should explore the substitution of other means to render services presently provided by FMG's in graduate education programs.

PROGRESS TOWARD ACCOMPLISHMENT:

The Executive Council approved the FMG Task Force recommendations, and they have been submitted to the AAMC constituency for reaction and comments. Ultimate implementation will depend on constituency interest and participation. The FMG Task Force report has been published as a supplement to the *J. Med. Educ.*, Vol. 49: No. 8, August, 1974:

The Association participated with the Coordinating Council on Medical Education in April 1975 in a National Invitational Conference on FMG's aimed at exploring with various organizations and government agencies the development of a national policy and program on FMG's. Recommendations of the Conference are under consideration by the CCME and the parent organizations.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of International Medical Education

AAMC COMMITTEE: FMG Task Force — discharged

ISSUE: WHAT SHOULD THE ROLE OF THE AAMC BE IN ENSURING THE VIABILITY AND INTEGRITY OF THE NIRMP?

The NIRMP was established in the early 50's to eliminate an increasingly chaotic competition for first-year graduate training positions. The elimination of an internship as a requirement for certain specialty residencies in the early 70's has resulted in multiple evasions of the program by both program directors and students. The problems are summarized in the article by Joseph Ceithaml, Ph.D., and Davis G. Johnson, Ph.D., "The NIRMP and Its Current Problems" (*J. Med. Educ.*, Vol. 48: 625-629, No. 7, July 1973).

PRESENT STATE OF POLICY DEVELOPMENT:

In 1972 the COD and CAS Administrative Boards expressed concern over NIRMP violations and adopted a statement which was approved by the Executive Council. It stated: "Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, the first hospital based graduate training appointment after the awarding of the M.D. degree should be through the National Intern and Resident Matching Program."

At the request of the Organization of Student Representatives and the Group on Student Affairs, an NIRMP Monitoring Program was approved by the Executive Council in June 1973. Announcement of the program was made in Deans Memo #74-7, February 1974. This program provides for reporting violations of the NIRMP to program directors through the office of the AAMC President, and the ultimate reporting of continuing violations to the NIRMP. The Administrative Board of the CAS has recommended the establishment of a Task Force to study NIRMP problems.

The Association, at every opportunity, has expressed its strong commitment to the viability and integrity of the NIRMP.

PROGRESS TOWARD ACCOMPLISHMENT:

Thirty-six schools have established NIRMP monitoring programs as recommended by the Executive Council. During 1974-75, the monitoring program was utilized by only one student who would allow personal identification. Formal notification of the program director resulted in clarification and correction of violations of the rules of NIRMP. Several instances of alleged violation of NIRMP rules without personal identification of the students involved were communicated to program directors informally.

The Executive Council in January, 1975 supported a position that accreditation of residency programs not be used to enforce NIRMP rules. The Executive Council informally concurred with asking the NIRMP Board to revise its Hospital Agreement form and require all residency program directors to sign the agreement. The Liaison Committee on Graduate Medical Education has developed a series of recommendations to NIRMP which will be further refined by the Coordinating Council on Medical Education.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs

AAMC COMMITTEE:

ISSUE: IS MOONLIGHTING BY HOUSE OFFICERS CONSISTENT WITH THE EDUCATIONAL CHARACTER OF HOUSE OFFICER TRAINING?

House officer engagement in extramural professional activities may endanger their educational experience and the patients charged to their care. On the other hand, house officers claim the right to engage in off-hours activities without prior approval; some localities have become dependent upon the off-duty physician in training to provide primary and emergency care; and the financial needs of some house officers may exceed the income derived from the training program.

PRESENT STATE OF POLICY DEVELOPMENT:

The Executive Council in the fall of 1973 charged a committee to study the question of house officer extracurricula activity and to develop recommendations for the management of this growing practice. It was the view of the committee that graduate medical education should be a full-time educational experience, and that moonlighting was inconsistent with the educational objectives of house officer training, and should be discouraged. The Executive Council approved this statement as AAMC policy on June 20, 1974. For those institutions which permit moonlighting, the following guidelines were recommended:

1. Approval or disapproval of moonlighting in the individual case should be administered by the hospital governing board, executive committee of the faculty, or the service chief or individual controlling the quality or content of the training program;
2. The training program for each house officer is to be evaluated with consideration given to the capacity of the house officer to fulfill his educational objectives and also engage in moonlighting; the nature and educational value of the work opportunity; the financial needs of the house officer; and the medical needs of the community;
3. No moonlighting should be permitted by interns and residents in programs approved by the Liaison Committee on Graduate Medical Education, except where this practice is approved and controlled by the person(s) responsible for the house officer's graduate training program. House officers should be informed of this requirement prior to appointment;
4. The Liaison Committee on Graduate Medical Education should take the necessary steps in its process of approval of graduate medical education programs to assure compliance with the above guidelines.

PROGRESS TOWARD ACCOMPLISHMENT:

These recommendations and guidelines on moonlighting have been distributed to the AAMC Assembly, for consideration at the institutional level.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE:

ISSUE: ARE INTERNS AND RESIDENTS PRIMARILY STUDENTS OR HOSPITAL EMPLOYEES?

Recent amendments to the National Labor Relations Act have brought all non-public health care facilities within the coverage of the Act. Housestaff organizations at several teaching hospitals have petitioned the National Labor Relations Board for recognition as bargaining units (unions). Although it is clear that the non-public teaching hospitals are now covered by the Act, at issue is the question of whether house officers are primarily students seeking graduate medical education or hospital employees providing services. Only if the NLRB considers the housestaff to be employees may it recognize their right to unionize.

PRESENT STATE OF POLICY DEVELOPMENT:

In early 1975 the Executive Council adopted the position that the primary purpose of interns and residents is to pursue graduate medical education and, therefore, they must be considered students. This position is consistent with the Association's adoption in 1973 of the LCME essentials of undergraduate medical education, *Functions and Structure of a Medical School*, which states, "The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period..." It is also consistent with the "Essentials of an Approved Internship" and the "Essentials of an Approved Residency," each of which has been approved by the AMA House of Delegates and will be acted upon by the LCGME, the CCME, and the AAMC. Each of these documents states that the primary purpose of intern and resident programs is education, the former specifically stating that "its educational function is of primary and paramount importance and its service function is secondary and incidental... No program designed primarily for service to the physician or the hospital can be considered as meeting the requirements of an approved internship."

PROGRESS TOWARD ACCOMPLISHMENT:

In April 1975, the Association filed an *amicus curiae* brief with the National Labor Relations Board, asking the Board to rule that interns and residents are not employees under the law and, therefore, are not subject to the jurisdiction of the National Labor Relations Act. This brief was filed in support of five teaching hospitals whose housestaff organizations were seeking NLRB recognition as bargaining units. A copy of the brief was mailed to all Assembly members.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Teaching Hospitals, Department of Academic Affairs

AAMC COMMITTEE:

ISSUE: WHAT IS THE APPROPRIATE ROLE OF THE MEDICAL SCHOOLS IN PROVIDING EFFECTIVE PROGRAMS OF CONTINUING MEDICAL EDUCATION?

Whether sponsored by medical schools, state or county medical societies or national specialty organizations, programs in continuing medical education for practicing physicians rely heavily upon the talents of the faculties of the Nation's medical schools. Because the demand for continuing medical education is rising, it is important that the faculty effort dedicated to this endeavor be as effective as possible.

PRESENT STATE OF POLICY DEVELOPMENT:

In March of 1973, the Executive Council of the AAMC adopted five propositions as the basis for developing a new thrust in continuing education. These were published in Vol. 8, No. 3, of the March 1973 issue of the *AAMC Bulletin*. The propositions are: 1. Medical faculties have a responsibility to impress upon students that the process of self education is continuous. 2. Medical faculties must cooperate with practicing physicians to develop criteria of optimal clinical management of patient problems. 3. Educational programs must be specifically directed toward improving detected deficiencies. 4. Evaluation of the effect of educational programs should be planned from their inception and should be based upon assessment of the modifications of the physician's day-to-day practice. 5. Financing of continuing education must be based upon a policy which recognizes its essential contribution to the progressive improvement of health care delivery. The Executive Council further recommended that the Group on Medical Education of the AAMC include within its members individuals from the medical schools who have responsibility for continuing medical education.

PROGRESS TOWARD ACCOMPLISHMENT:

The Group on Medical Education now includes individuals from the medical schools responsible for continuing medical education.

At the time of the formation of the Liaison Committee on Continuing Medical Education (a committee under the CCME), the Association insisted that the purpose of this Liaison Committee should first be to provide a body for developing new principles and policies for continuing medical education, its supervision and accreditation.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs

AAMC COMMITTEE: CCME

ISSUE: SHOULD PERIODIC RECERTIFICATION AND RELICENSURE OF PHYSICIANS BE REQUIRED?

During the last five years, there has been an increasing interest by specialty boards and state licensing boards in the concept of requiring that physicians be periodically recertified or relicensed. Recertification or relicensure are generally conceived to be based upon evidence that the physician has participated in continuing education or passed an examination or both. There appears to be a consensus that recertification or relicensure requirements will improve the quality of medical care delivered, even though there is little or no evidence that this will be an outcome of such requirements.

PRESENT STATE OF POLICY DEVELOPMENT:

A preliminary draft of a position was reviewed by the Graduate Medical Education Committee in early March 1974. The Committee requested that further investigation be done regarding the potential effects of recertification on the day-to-day practice of medicine by physicians. The Committee is also concerned that should recertification and/or relicensure become a common-place requirement, the demand for educational services from physicians now in practice may increase enormously; and such an increase will require that appropriate planning for expanding educational resources in this country will be needed.

It has been determined that all twenty-two specialty boards have endorsed the concept of recertification. Two states have already adopted laws requiring relicensure. The American Board of Internal Medicine administered a voluntary recertification exam in the Fall of 1974 as the first phase of a long-range recertification effort. The following Boards have proposed dates for recertification exams: Family Practice — 1976, Physical Medicine and Rehabilitation — 1977, Otolaryngology — 1978, Plastic Surgery — 1978, Colon and Rectal Surgery — 1985. The American Board of Surgery plans recertification for all those certified after September 1, 1975, on a ten-year cycle.

PROGRESS TOWARD ACCOMPLISHMENT:

Efforts to identify methodologies to assess competence are going on in several quarters, including the AAMC's Division of Educational Measurement and Research and National Board of Medical Examiners. All bodies currently concerned with recertification are uncomfortable with basing recertification solely upon passing a cognitive examination.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Educational Measurement & Research

AAMC COMMITTEE:

ISSUE: WHAT FACTORS SHOULD DETERMINE THE RATE AND EXTENT OF FUTURE EXPANSION OF MEDICAL SCHOOL CLASS SIZE?

The Comprehensive Health Manpower Training Act of 1971 established enrollment expansion as a prerequisite for Federal capitation support. Medical schools responded to this incentive by dramatically increasing class size. As renewal of this legislation is debated, the issue of whether additional enrollment increases should be Federally-mandated has surfaced.

PRESENT STATE OF POLICY DEVELOPMENT:

Although in 1968 the AAMC and the AMA jointly endorsed the position that medical schools should "accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted," this position was soon afterward considered to be impossible to attain. In 1970, the AAMC, following the recommendations of its Committee on the Expansion of Medical Education (Howard Committee), modified this endorsement to propose that by 1975, medical school first year enrollment should increase to 15,000 students, and be maintained at that level. This was felt to be sufficient to overcome the shortage of physicians. (See *J. Med. Educ.*, Vol. 46: 105-116; No. 2, February 1971).

The AAMC currently supports expansion of medical school class size *in relation to the need for physicians*. The Association recognizes that determining the need for physicians is a complex question which must take into account problems of geographic and specialty maldistribution. However, because of limited financial resources for medical education and in an effort to maintain quality in education and care, the Association believes that medical school enrollments should increase only to reflect the nation's requirements for physicians.

PROGRESS TOWARD ACCOMPLISHMENT:

The Howard Committee goal of an entering class of 15,000 students by 1975-76 will most likely be met. The Association, in discussions with Federal policy-makers, has opposed measures which would require expansion regardless of future manpower projections.

The Association is attempting to identify physician manpower studies which might contribute to the current perceptions of physician need.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

ISSUE: WHAT IS THE APPROPRIATE DISTRIBUTION OF EFFORT IN ACADEMIC MEDICAL CENTERS BETWEEN HEALTH SERVICES ESSENTIAL TO EDUCATION AND HEALTH SERVICES UNDERTAKEN IN RESPONSE TO OTHER SOCIAL NEEDS?

Academic medical centers have offered a broad range of inpatient and ambulatory services, primarily as an outgrowth of the educational process. These services have had an increasing impact on the communities in which they exist. Questions arise as to the extent of the center's responsibilities for developing educational and service programs reflecting local needs and resources.

PRESENT STATE OF POLICY DEVELOPMENT:

Because of the great variation in medical center settings, this issue must be addressed by each constituent institution, taking into account local needs, resources and interests.

PROGRESS TOWARD ACCOMPLISHMENT:

To assist the institutions establishing these policies, two major staff activities are underway:

1. The Health Services Advisory Committee is presently considering this problem from three perspectives:
 - a) The roles of faculty
 - b) Determination of program responsibilities for patient care and community service.
 - c) The types of governance structures that would resolve these issues.
2. The AAMC Management Advancement Program and related institutional studies are directed toward the determination of institutional objectives and organizational structure appropriate to the role of the individual academic medical center in responding to societal and community needs. Not infrequently the work of the institution team at Phase II MAP seminars has focused on specification of medical center objectives and the design of an action plan relative to achieving these objectives.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services; Department of Institutional Development; Department of Teaching Hospitals

AAMC COMMITTEE: Health Services Advisory Committee; Management Advancement Program Steering Committee

ISSUE: WHAT FACTORS INFLUENCE THE EFFECTIVENESS OF AFFILIATION ARRANGEMENTS BETWEEN MEDICAL SCHOOLS AND TEACHING HOSPITALS?

Increasingly, the non-university owned and/or non-university affiliated (community based) teaching hospital is becoming more involved in providing clinical settings for undergraduate medical education. This appears to be the result of two somewhat parallel developments. First, medical schools in the planning and development state are choosing to use presently existing community facilities to accomplish specific educational objectives or are finding it increasingly difficult to secure the necessary funding to build and subsequently operate a university-owned hospital facility. Second, established medical schools are increasingly looking toward community based hospital facilities to provide clinical settings whereby class size can be increased and/or a broader clinical exposure can be provided physicians in training.

PRESENT STATE OF POLICY DEVELOPMENT:

Work in the area of affiliation arrangement, sponsored by the AAMC, is as follows: (1) Cecil G. Sheps, et. al., "Medical Schools and Hospitals: Interdependence for Education and Services," (*J. Med. Educ.*, Vol. 40:, September (Part II), 1965); (2) George Wolf, et. al., "Report of the Second Administrative Institute on Medical School-Teaching Hospital Relations," (*J. Med. Educ.*, Vol. 40: November (Part II), 1965); and (3) Patricia Kendall, "The Relationship Between Medical Educators and Medical Practitioners," (*J. Med. Educ.*, Vol. 40: January (Part II), 1965.) At the time this work was completed the number of medical schools and the nature of their relationships with teaching hospitals were relatively stable. Due to the emergence of new (and new types of) medical schools and the development of innovative patterns of clinical experiences constructed by established medical schools, the factors that influence the effectiveness of affiliation arrangements should be reexamined.

PROGRESS TOWARD ACCOMPLISHMENT:

Planning is underway to establish a joint AAMC-AHA working group that would examine alternative approaches to addressing issues related to affiliation arrangements between medical schools and teaching hospitals. This group would provide general direction for any efforts in this area (investigations, conferences, etc.)

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Teaching Hospitals; Department of Institutional Development

AAMC COMMITTEE:

ISSUE: SHOULD THE AAMC ASSIST THE MEDICAL SCHOOLS IN STRENGTHENING THEIR CAPABILITY FOR DEALING WITH MATTERS THAT ARE CONSIDERED ORGANIZATIONAL MANAGEMENT PROBLEMS?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC responded affirmatively to this issue in 1971 and, with the guidance of representatives of the Council of Deans, set about to identify needs in this area and design specific programs in response. This effort was endorsed by the December, 1972 AAMC Officer's Retreat and the Executive Council.

PROGRESS TOWARD ACCOMPLISHMENT:

Three specific programs have been implemented:

1. The Management Advancement Program

Executive Development Seminar (Phase I)
Institutional Development Seminars (Phase II and III)

By September 1975 over 90 deans will have participated in Phase I; over 50 schools will have participated in Phase II; and 13 institutions will have attended Phase III. Future Executive and Institutional Development Seminars are being scheduled at regular intervals. A second Robert Wood Johnson Foundation grant will provide program support for an additional three years through June 1977.

2. Institutional Studies

This effort involves the study and analysis of the common body of law and practice in the medical schools relative to institutional organization, governance and management. The delineation of areas being studied is related closely to the kinds of questions asked by the constituency: medical school/center organizational models, analysis of patterns of governance, and trends in medical school management are the types of general categories covered. These studies are supported under contract with BHRD.

3. Management Systems Development

This effort involves an exploration of the "state of the art" of management systems utilization in the medical schools and the means by which the AAMC might enhance management effectiveness through facilitating the development of more refined or appropriate instruments.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development; Department of Program Planning and Policy Development

AAMC COMMITTEE: Management Advancement Program Steering Committee; Management Systems Development Liaison Committee

ISSUE: HOW SHOULD U.S. MEDICAL SCHOOLS RELATE TO COUNTERPART INSTITUTIONS ABROAD?

Some U.S. medical schools have a long tradition of relating to selected institutions abroad particularly in the developing world. These "technical assistance projects" are gradually being changed into cooperative projects in areas of mutual interest. Such conjoint projects are best realized by a combination of efforts on institutional and national levels.

PRESENT STATE OF PROGRAM DEVELOPMENT:

AAMC, through its Division of International Medical Education, is working closely with counterpart organizations abroad such as the Panamerican Federation of Associations of Medical Schools, the Association of Medical Schools in Africa, the Association for Medical Education in Europe, the Indian Association for Medical Education, and others. The object of these conjoint efforts is to develop projects dealing with relationships between medical education and community health, be it at the level of community medicine, national health planning, health systems research or others. The ultimate goal is to prepare the young physician for an expanded role in community medicine affairs by adding new dimensions to the educational experience offered by the medical schools.

PROGRESS TOWARD ACCOMPLISHMENT:

1. Study of community medicine involvement of medical schools in four developing countries (Colombia, Ethiopia, Thailand and Turkey) has been accomplished under a contract with AID;
2. A project to promote relationships between medical schools and social security institutions in Latin America is in progress in collaboration with PAFAMS;
3. Participation in a family health training project in health professions education institutions in Africa with the North Carolina Population Center;
4. Study of impact of national health systems on medical education in Canada, Great Britain, and Sweden is in progress.

Report on Project 1 is available while a report on Project 2 is in preparation.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of International Medical Education.

AAMC COMMITTEE: Committee on International Relations in Medical Education and Community Medicine Study Groups

ISSUE: HOW SHOULD THE RESPONSIBILITY FOR FINANCING UNDERGRADUATE MEDICAL EDUCATION BE DISTRIBUTED?

Until the 1960's the costs of undergraduate medical education were borne by students through tuition charges, income from endowments and gifts, and state appropriations for publicly supported schools. Federal support began in 1963 through students loans and construction grants. This support has been broadened to include scholarships, capitation grants and funds to carry out special projects to improve educational programs and to advance Federal initiatives.

PRESENT STATE OF POLICY DEVELOPMENT:

In the 1950's the Association adopted a policy calling for Federal support to supplement other sources of financing of medical education. Subsequently, the Executive Council has endorsed positions recommended by its committees and task forces calling for multiple sources of support for the costs of medical education from the public and private sectors with a larger and more appropriate share from the Federal government.

In 1970 the Executive Council appointed a Committee on the Financing of Medical Education to make more specific policy recommendations on the responsibility of the public and private sectors and students in meeting the costs of medical education. The Executive Council has approved the two reports prepared by the Committee. The first report – "Undergraduate Medical Education – Elements – Objectives – Costs", identified the costs of the undergraduate medical education program. The second report "Financing Undergraduate Medical Education" – presented recommendations on how undergraduate medical education should be financed.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has promulgated widely its policies on the financing of medical education. Through its activities with the Congressional and Executive branches of the Federal government, it has been involved with the development and enactment of legislation to establish and extend the Federal support of medical education. In testimony before appropriation committees, it has pressed for the funding of legislation authorizing Federal support.

The Association participates in the Federation of Associations of Schools of the Health Professions to promote a unified policy for Federal support of health professions education. It has obtained the support for Association policy positions from a number of other organizations including the American Council on Education, the Association of American Universities, the American Medical Association, and the American Hospital Association.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE: Committee on the Financing of Medical Education; Committee on Health Manpower

ISSUE: HOW SHOULD THE RESPONSIBILITY FOR FINANCING GRADUATE MEDICAL EDUCATION BE DISTRIBUTED?

The principal source of support for graduate medical education has been through reimbursement for health services rendered in the teaching hospital. The training grant programs of the National Institutes of Health have provided support for the preparation of physicians for careers in biomedical research and in the subspecialties. Both the payment of resident stipends from reimbursement for health services and training grants has come under attack. There is not an adequate source of support for graduate medical education in the ambulatory setting which impedes attempts to increase the number of primary care physicians.

PRESENT STATE OF POLICY DEVELOPMENT:

The National Health Insurance Task Force, as a part of their recommendations on Association policy, has stated, "National health insurance is an appropriate mechanism for financing graduate medical education as a means of replenishing the health manpower pool. Graduate medical training includes important elements related to education and delivery of health services as integral parts of the training, and is thus appropriately financed by the health delivery system, both with respect to inpatient and ambulatory care." This report was approved by the Executive Council on June 21, 1974.

The Committee on the Financing of Medical Education is charged with developing a position on financing graduate medical education for consideration by the Councils of the Association. Because of pressures to make recommendations on the financing of undergraduate medical education, it has not yet turned its attention to this issue. The Graduate Medical Education Committee, which has interacted with the Committee on the Financing of Medical Education has informally reviewed and endorsed the recommendations of an *ad hoc* Committee of the Coordinating Council on Medical Education (CCME) that residency training is a legitimate cost of medical care. When approved by the CCME, the recommendations of the *ad hoc* Committee will be referred to the AAMC for its consideration. The recommendations will be referred to the Committee on the Financing of Medical Education and the Graduate Medical Education Committee for their review and recommendations and with the recommendations of the National Health Insurance Task Force may form the basis of an Association policy position after consideration by the Councils.

PROGRESS TOWARD ACCOMPLISHMENT:

Graduate medical education is now financed primarily through health services income. Unless alternate methods of financing are recommended by the Committees of the AAMC and the CCME and approved by the Councils, the Association will continue to support present arrangements for financing graduate medical education.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE: Committee on the Financing of Medical Education; Graduate Medical Education Committee

ISSUE: HOW SHOULD THE DETERMINATION OF THE COST OF MEDICAL EDUCATION BE APPROACHED?

Program cost determination is a valuable tool for self-study. With great care to assure a uniform and satisfactory methodology, it can also be used for interinstitutional comparison. Such studies do have limitations, however, which tend to obscure the interrelationships of programs in the academic medical center.

The Comprehensive Health Manpower Training Act of 1971 (Section 205) required the development of "National uniform standards for determining annual per student educational costs for each health professional school in the future year." The schools may in the future be required to report costs annually as a basis for capitation.

PRESENT STATE OF POLICY DEVELOPMENT:

Since the mid-fifties, the AAMC has assisted the nation's medical schools in the conduct of cost allocation studies, with the objective of providing a mechanism for self-study; uniform guidelines developed by AAMC were employed, but details of the application differed.

The Committee on the Financing of Medical Education was formed in 1970, and the Committee immediately turned its attention to a determination of the costs of medical education. The Committee developed a methodology which recognized that biomedical research and clinical experience are essential components of education, and which took account of resource costs presently financed through voluntary contributions and joint programs with affiliated institutions. The Committee's report was approved by the Executive Council.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC continues to support self-study through program cost finding at the individual medical schools. The Committee's report, "Undergraduate Medical Education: Elements - Objectives - Costs," (*J. Med. Educ.*, Vol 49: 97-128, January, 1974), has been distributed to members of the U.S. Senate and House of Representatives, members of the Administration, and key decision makers at the state level.

The Institute of Medicine has completed a study of the cost of education in the health professions, with results in broad agreement with the AAMC report. Association staff consulted with IOM staff during the conduct of this study. IOM now has the task of developing a uniform cost determination methodology for future reporting, and the Association has nominated individuals to serve on the IOM Committee overseeing this activity.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE: Committee on the Financing of Medical Education

ISSUE: WHAT FEDERAL, STATE AND PRIVATE SOURCES OF FINANCIAL ASSISTANCE SHOULD BE AVAILABLE TO STUDENTS?

Financial aid to medical students is becoming a major issue; rising tuition charges and increases in the cost of living are placing severe demands upon the resources available for financial aid. Coupled with this stress is a developing attitude, particularly in the Federal government, that the cost of higher education and particularly medical education should principally be borne by the students who ultimately benefit through increased income potential during their working years.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly in 1970 passed an equal opportunity resolution. Contained in this resolution is the recommendation that the Association and the schools design programs to eliminate economic barriers to education in the health professions.

The Association has assumed the position that a principle resource for student financial aid should be the Federal Government. The Executive Council at its January 1975 meeting adopted the recommendations of the Task Force on Health Manpower on the student assistance provisions to be proposed for the extension of the health manpower legislation. These recommendations include (1) increased authorizations for National Health Service Corps medical school scholarships up to four years at \$6,750 a year plus tuition, in return for year-to-year service (minimum of two years), after residency training, in the Corps or other approved area; (2) health professions loans at \$3,000 a year plus tuition, to be made available only to students with exceptional financial need, with forgiveness of 25 percent of the loan for every year of practice in a designated shortage area; and (3) health professions scholarships at \$3,000 a year, plus tuition for first and second year students of exceptional financial need.

The Association has no position on the specific obligations of states for the provision of financial aid to medical students.

Various types of loan and scholarship funds from private sources have been studied by committees of the Group on Student Affairs, including the educational opportunity bank concept; but an Association position on a specific program has not been developed.

PROGRESS TOWARD ACCOMPLISHMENT:

In cooperation with the Bureau of Health Resources Development with the advice of the GSA Committee on Financial Problems of Medical Students and the GSA Medical Student Information System Committee an anonymous survey to determine how students finance their medical education is underway. Workshops directed toward improving the management of the financial aid officers in medical schools and increasing the knowledge of financial aid officers regarding sources of funds were held in 1974 in all regions.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs/Division of Student Services/Division of Student Studies

AAMC COMMITTEE: GSA Financial Problems of Medical Students

ISSUE: SHOULD MEDICAL SCHOOL ADMISSIONS BE ADMINISTERED THROUGH A NATIONAL MATCHING PROGRAM?

The increasing number of applications to medical schools has made it more and more difficult to operate the selection system for medicine in a fashion which provides an optimal opportunity for both the students and institutions to make decisions which are satisfactory to both parties. The successful experience with the National Intern and Resident Matching Plan has led many to suggest that a matching plan for admission to medical schools should be instituted.

PRESENT STATE OF POLICY DEVELOPMENT:

In response to a recommendation from the Council of Deans and with the assistance of the Henry J. Kaiser Family Foundation, AAMC conducted a pilot medical school admissions matching program parallel to the 1974 application cycle. Evaluation of the Study was completed in February 1975. It was concluded that matching as a method of medical student selection while technically feasible would not decrease the number of applications filed and that it would be unlikely that all schools could conform to the required strict timetable. As a result, on April 3, 1975, the COD Administrative Board approved a recommendation that matching not be implemented or studied further as an advantageous method of medical student selection for any reason at this time.

PROGRESS TOWARD ACCOMPLISHMENT:

As a result of the deans' recommendation, the Association has no plans to pursue a national matching program.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs

AAMC COMMITTEE: *Ad Hoc* Steering Committee on the Pilot Implementation of a Medical School Admissions Matching Plan

ISSUE: SHOULD SELECTION FACTORS FOR ADMISSION TO MEDICAL SCHOOL INCLUDE CRITERIA OTHER THAN THOSE RELATED TO ACADEMIC POTENTIAL?

Medical schools have traditionally utilized a variety of criteria in making selections for admission to their undergraduate medical programs. In addition to previous academic achievement and scores attained on the Medical College Admissions Test, these criteria have included letters of recommendation from premedical advisors or instructors, students' preceptions of their own achievements as recorded in biographical essays, and impressions gained from interviews by members of the medical school faculty.

These subjective criteria are considered highly important by the institutions in making selection decisions. There is a desire to make the interpretation of these criteria more sound.

PRESENT STATE OF POLICY DEVELOPMENT:

The selection of students for admission to medical school is the responsibility of the faculty of each institution. Within this framework, the AAMC assists the institutions in identifying criteria which might influence admissions decisions. In an *amicus curiae* brief filed in the case of *DeFunis v. Odegaard*, 94 S.Ct. 1704 (1974), the AAMC argued that quantifiable predictors of academic performance should not be the sole criteria for admission.

The Executive Council in June 1974 endorsed the recommendations of a review committee on the Medical College Admission Assessment Program, asking that the Association seek outside support to develop non-cognitive assessment criteria which might be utilized by the institutions. Areas specifically identified for research were problem-solving skills, communication skills, biographical information, and criterion measures of clinical performance.

PROGRESS TOWARD ACCOMPLISHMENT:

The Committee on Admissions Assessment has established a task force charged with the responsibility of surveying approaches now being utilized in assessing these criteria. This task force is analyzing information received from individuals and institutions working in this field and will make recommendations to the Committee on Admissions Assessment regarding the development of a research proposal.

A complementary activity is the Longitudinal Study of the Class of 1960. This study provides an opportunity to correlate the characteristics of students upon admission to medical school with their eventual career selection and practice performance. As these studies proceed, it is anticipated that the information will be utilized to make recommendations to the institutions regarding the reliability of non-cognitive selection criteria.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Educational Measurement and Research/ Division of Student Studies

AAMC COMMITTEE: Committee on Admissions Assessment; Ad Hoc Longitudinal Study Advisory Committee

ISSUE: WHAT SHOULD BE THE NATIONAL GOAL IN EDUCATING MINORITY STUDENTS IN MEDICINE?

Students from certain minority groups in the United States have been significantly under-represented in medicine. These groups include Black-Americans, Mexican-Americans, American-Indians, Mainland Puerto Ricans and disadvantaged Caucasians. As a result of the nationwide concerns regarding minority opportunities which developed during the 1960's, major efforts have been developed to increase the opportunities for students from these minority groups to study medicine.

PRESENT STATE OF POLICY DEVELOPMENT:

In May of 1970, the Executive Council accepted the AAMC Task Force Report to the Interassociation Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students. In December 1970, the Executive Council approved a policy statement calling for a short-term objective of increasing minority enrollment to 12% by the year 1975-76 in the Nation's medical schools. The policy statement also recommended the development of minority affairs offices in the medical schools and an expanded Minority Affairs Office at the Association. The policy statement recommended that medical school curricula should be modified to adapt to the differences in preparation of minority students in the traditional sciences and that financial constraints for minority students should be minimized.

PROGRESS TOWARD ACCOMPLISHMENT:

The Office of Minority Affairs of the Association distributes a Medical Minority Applicant Registry (MED-MAR) and will publish the revised edition of "Minority Student Opportunities in U.S. Medical Schools" (MSOUSMS), as well as "Minorities and the Health Professions." MED-MAR has been directed toward identifying disadvantaged students seeking medical careers, while MSOUSMS describes medical schools' programs to attract applicants from disadvantaged groups. The publication "Minorities and the Health Professions," an annotated bibliography, provides a source of information concerning the attitudes and characteristics, as well as the academic and professional aspirations of disadvantaged students. Through an OEO grant, various programs directed toward recruiting and retaining disadvantaged students in the health professions were supported in various institutions in the United States.

Five regional workshops directed toward improving selection systems for disadvantaged students and assisting schools in meeting the particular cultural and educational needs of these students have been held with 108 medical schools represented. A Simulated Minority Admissions Exercise (SMAE) system has been developed for utilization by admissions committees to improve their identification of specific variables pertinent to the selection of non-traditional group applicants. After initial trial this program is being adapted to emphasize the selection factors important in identifying capable non-traditional applicants of all categories. Requests for this training service from admissions committees have been growing.

Enrollment of under-represented minorities (Black-Americans, American-Indians, Mexican-Americans, and Mainland Puerto Ricans) in first-year medical school classes was 4.8 percent in 1969-70, 7.0 percent in 1970-71, 8.6 percent in 1971-72, 8.6 percent in 1972-73, 9.2 percent in 1973-74 and 10.0 percent in 1974-75.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs: Office of Minority Affairs

AAMC COMMITTEE: GSA Committee on Medical Education of Minority Group Students

ISSUE: SHOULD MORE WOMEN BE ENCOURAGED TO ENTER THE MEDICAL PROFESSION?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC has clearly enunciated a policy of no discrimination in admission of students to medical school and in employment on the basis of sex. It has not, however, advanced a policy that more women should be encouraged to enter the medical profession.

PROGRESS TOWARD ACCOMPLISHMENT:

In response to the numerous requests for information about women in medicine from students, faculty, medical school administrators and professional and scientific organizations, the AAMC is attempting to organize data available on this subject. Drawing on the existing and extensive AAMC sources, including Student Information, Faculty Profile Studies, the Longitudinal Study, etc., we have attempted to coordinate the pooling of information pertaining to women in medicine. A special effort has been made to gather information from a wide variety of sources outside the AAMC and to represent the AAMC to the extent possible on an ad hoc basis at meetings and conferences which deal in a significant and relevant way with the subject of women in medicine.

Additionally, the Association will focus on the special problems encountered by women who choose medicine as a career and, for example, has established a Staff Task Force on Affirmative Action to develop means by which the AAMC might assist schools in meeting requirements for affirmative action.

An office focused on Women in Medicine has been approved in principle and staffed on a collateral duty basis, but has not been formalized organizationally. A project has been outlined which would bring to bear considerable knowledge and expertise about the question posed by this issue. This was being discussed with the Radcliffe Institute as a joint project and planning funds were sought from foundations, but without success. The press of other work has precluded additional effort directed toward raising the funds for the policy development effort or any full time staff.

The enrollment of women in first-year medical school classes was 9.1 percent in 1969-70, 11.1 percent in 1970-71, 13.7 percent in 1971-72, 16.8 percent in 1972-73, 19.7 percent in 1973-74, and 22.2 percent in 1974-75.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE:

ISSUE: WHAT IS THE RESPONSIBILITY OF THE AAMC FOR PROVIDING COMPLETE AND ACCURATE INFORMATION TO POTENTIAL APPLICANTS TO MEDICAL SCHOOL?

For both selfish and altruistic reasons, the AAMC should provide increasingly complete and accurate information to potential applicants. Such information should help reduce the wasteful admissions processing caused by the hundreds of thousands of applications per year filed by individuals with no real chance of serious consideration by the U.S. medical schools to which they apply. Such information should also help discharge a moral obligation to help reduce the frustration experienced by the tens of thousands of applicants per year who are rejected by all medical schools after spending untold years and dollars preparing for a career which they never had any realistic chance of entering.

PRESENT STATE OF POLICY DEVELOPMENT:

Established by action of the Assembly, 1973, as reported on page 4 of the November, 1973 *AAMC Bulletin*, the Assembly "approved two OSR-sponsored resolutions calling for the AAMC to gather and disseminate more data on medical school admissions to prospective applicants and premedical advisors." The first resolution asked the AAMC to annually request its member schools to submit information on GPA, MCAT, college majors, sex and minority group composition of students in as recent a freshman class as possible for inclusion in each year's edition of *Medical School Admission Requirements (MSAR)*. It further encouraged schools to submit data on other variables and recommended that GPA and MCAT data be presented in one of a number of "sample standard formats" to be suggested by the AAMC. The second resolution called for the AAMC to encourage and assist undergraduate colleges in providing information to their premedical students regarding the results of applications to medical schools from their preceding classes of premedical students.

PROGRESS TOWARD ACCOMPLISHMENT:

Relative to the first resolution, the AAMC requested much more detailed information from the schools for the 1975-76 edition of MSAR. For several years, the schools participating in AMCAS have been providing such details in the annually revised "AMCAS Information Booklet." Experimentation is already under way with the "sample standard format" for GPA and MCAT data and at least one format will probably be included in the 1972-73 Study of Applicants. Concerning the second resolution, the AAMC initiated in 1974 a service for health professions advisors which provides at nominal cost (1) Summary Reports of the Admissions Status for National and Individual Undergraduate School Applicant Pools and (2) Rosters of Applicants from one's Undergraduate School. A related long-range development is the proposed "Career Guidance Booklet" for high school and entering college students which has been recommended by the MCAAP Task Force.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Studies; Division of Student Programs; Division of Educational Measurement and Research; Division of Publications

AAMC COMMITTEES: GSA Committee on Relations with Colleges and Applicants; Ad Hoc Review Committee to Study and Evaluate the Report of the MCAAP Task Force

ISSUE: DOES THE AAMC OR ITS MEMBER INSTITUTIONS HAVE AN OBLIGATION TO FACILITATE THE CAREER DEVELOPMENT OF U.S. CITIZENS STUDYING MEDICINE ABROAD?

It is estimated that there are between four and six thousand United States citizens studying in medical schools abroad. Most, if not all, of these students have sought medical education abroad with the expectation that they will be able to return to the United States and develop careers as physicians. Many students desire to transfer with advanced standing to U.S. schools. For all students, the opportunity to complete their career development is dependent upon their gaining access to graduate medical education in the U.S.

PRESENT STATE OF POLICY DEVELOPMENT:

In 1970, the Association instituted the Coordinated Transfer Program (COTRANS) to facilitate U.S. citizens in foreign medical schools obtaining information regarding which schools might accept them as transfers at the clinical level and to sponsor eligible applicants for Part I of the NBME.

In 1972, the Executive Council recommended that the "Fifth Pathway" alternative, developed by the Council on Medical Education of the AMA, not be endorsed and that the medical schools should become more heavily involved in utilizing the COTRANS program to facilitate the transfer of qualified U.S. citizens studying medicine abroad into United States medical schools.

The FMG Task Force report, approved by the Executive Council in March 1974, recommends that the AAMC and interested medical schools sponsor a pilot project to identify and correct educational deficiencies in FMG's, particularly U.S. citizens, and to bring them to a level of professional competence comparable to domestic graduates. This report also recommends that a uniform qualifying examination be administered to all graduates of U.S. and foreign medical schools seeking graduate training in this country.

The Association participated April 20-22, 1975 with CCME in a National Invitation Conference on FMGs aimed at exploring the possible development with other organizations of national policy and programs on FMGs. The Conference recommended that both COTRANS and the Fifth Pathway be endorsed as mechanisms by which U.S. citizens might re-enter the medical education system of this country.

PROGRESS TOWARD ACCOMPLISHMENT:

Presently, 50 medical schools are listed in the COTRANS program as being interested in accepting U.S. citizens currently in foreign medical schools. In the first five years of its existence, COTRANS sponsored 3,150 NBME Part I examinations, of which 1,044 or 33 percent were passing. A total of 826 COTRANS-sponsored examinees were admitted as transfers to U.S. medical schools from 1970 to 1974 (see DATAGRAM, *J. Med. Educ.*, Vol. 50, 208-211, February, 1975).

The AAMC is currently seeking foundation support to implement the pilot project mentioned above. As pressures from this large contingent of U.S. citizens mount, medical schools may be asked to develop special undergraduate and graduate programs to facilitate the career development of this group.

The Association is studying the degree to which the medical schools are currently participating in Fifth Pathway programs. As a means of developing a control mechanism, the Association also will explore with ECFMG the possibility of reviewing Fifth Pathway participants as part of its certification process.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/
Division of Student Services; Division of International Medical Education

AAMC COMMITTEE:

ISSUE: WHAT SHOULD BE THE MAGNITUDE OF OUR NATIONAL EFFORT IN BIOMEDICAL RESEARCH?

The total national health cost rose from approximately \$26 billion in 1960 to \$104 billion in 1974. During the same interval, Federal health expenditures rose almost ten-fold from \$3 billion to almost \$28 billion. National expenditures for biomedical research in 1974 were \$4.3 billion which contrasts with an expenditure of \$0.84 billion in 1960. Two-thirds of our national expenditures for biomedical research and development derive from Federal sources, 28% from industry and 7% from other private and public sources.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC policy on this matter is articulated in the document entitled, "A Policy for Biomedical Research," (*J. Med. Educ.*, Vol. 46: 689-743, No. 8, August 1971). It is recommended that the Nation adopt a policy supporting more, rather than less, biomedical research, in full recognition of the fact that no other course can offer hope for ultimate solutions to health problems. It was further recommended that the national policy for biomedical research assure support at levels sufficient to engage all qualified brainpower and that consideration be given to expansion at a rate determined by widening research opportunities.

The Committee on Biomedical Research and Research Training has recently reviewed this matter and has recommended that 5% of our national health expenditures be earmarked for the support of biomedical research. This is a very low rate of investment for the development of new knowledge and technology for our national health industry which is rooted in scientific and technologic innovation. Most technologically based industries devote more than 5% of their resources to research and development activities.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC was instrumental in establishing the Coalition for Health Funding, which represents over 40 organizations concerned that Federal health programs are adequately funded. AAMC officers have testified on research appropriations and have encouraged other organizations to support research funding.

In 1973, the Association successfully brought suit forcing the expenditure of Congressionally-appropriated research money which had been impounded by the Executive branch.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/
Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: HOW AND BY WHOM SHOULD NATIONAL RESEARCH PRIORITIES BE DETERMINED?

Traditionally, the budget of the NIH and the NIMH had been determined following a dialogue which involved the Executive and Legislative branches of the Federal government, the public and the various non-profit, voluntary health organizations. The budgets of the NIH and NIMH have been presented to the Congress and the public in such a manner that an interested person or group could evaluate the planned Federal expenditures in an area of concern without much difficulty and could then express his interest in changing the allocation of resources to the legislature. Recently, there has been discussion of presenting the budget of the NIH and the NIMH to the Congress as a single line item rather than the usual institute by institute fashion.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association of American Medical Colleges believes that the allocation of resources to our national biomedical research effort and the distribution of these resources should be the subject of a public debate involving both the various branches of the government and the public. Presentation of the budget of the NIH or the NIMH as a single line item would usurp the opportunity for individuals and organizations interested in various aspects of the Federal budget to have an opportunity to express their concerns before Congress.

The Association also supports the role of the national advisory councils, which provide both public and scientific input into determining which research programs within an institute deserve priority in funding.

The Executive Council on June 21, 1974 endorsed the recommendations of the Conference on Biomedical Research Manpower, sponsored by the AAMC Council of Academic Societies in October 1973. The conference recommended the establishment of a study group to suggest guidelines for the allocation of resources to basic and applied biomedical research.

PROGRESS TOWARD ACCOMPLISHMENT:

In testimony before Congress, letters to the Secretary of HEW, and discussion with Federal officials, the Association has strongly supported the role of Congress and the advisory councils in determining Federal research priorities. The AAMC has urged that appointments to study sections and advisory councils not be influenced by the political affiliation of the nominee.

The Association has recommended to HEW officials that the President's Biomedical Research Panel, established by the National Cancer Act Amendments of 1974, be requested to examine the substantive character of the nation's current biomedical research effort; the basis upon which a national program of biomedical research should be established, and the resources required to implement and maintain that policy. These matters have been fully explored in discussions with the Panel by representatives of the Council of Deans, and Council of Academic Societies.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: HOW AND BY WHOM SHOULD BIOMEDICAL RESEARCH PROPOSALS BE EVALUATED?

External peer review has been a useful tool to guide the investment of research resources into those areas which hold the greatest promise for significant yield from research. Recently, certain individuals within the Federal government have questioned whether the external peer review system is a cost-effective management tool. In contrast, the scientific community is convinced that external peer review has been the key element in the success of our national biomedical research program.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has strongly endorsed the principle of external peer review of research proposals. The AAMC believes that external peer review of individual project grants and contracts, as well as requests for proposals, will ensure that our national biomedical research and development resources are allocated to problems of high relevance. External peer review of individual proposals utilizing scientific merit as the primary criterion will ensure that funds are disbursed within the broad policy guidelines established by the legislature.

PROGRESS TOWARD ACCOMPLISHMENT:

The Executive Council of the Association, the Council of Academic Societies Administrative Board and the Committee on Biomedical Research and Research Training have met with various officials of the Department of HEW, the NIH Director's staff, the Director of the Heart and Lung Institute and the Director of the National Cancer Institute to discuss this matter and to offer its concern about the allocation of resources without external peer review.

In testimony before Congress, the Association has endorsed the current NIH and NIMH review system and has urged that appointments to study sections and advisory councils not be influenced by the political affiliation of the nominee.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/
Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: WHAT IS THE APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT IN THE SUPPORT OF TRAINING OF BIOMEDICAL RESEARCH SCIENTISTS?

The major health problem for the United States is the continued existence of incapacitating or fatal diseases for which we have neither adequate treatment nor mechanisms for cure. Research in the biomedical sciences offers the only rational approach to this problem. Excellence in research does not automatically follow the flow of funds into a field. It requires the recruitment, training, and cultivation of that relatively small number of individuals capable of working at the frontiers of scientific creativity. The predominant role of the Federal government in the support of the nation's biomedical research enterprise is well established; it, therefore, follows that the Federal government should also accept the responsibility for assurance of the quality and quantity of the nation's biomedical research manpower pool.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has been actively concerned with ensuring adequate support for the training of biomedical research scientists. Formal policy of the Association on this issue is articulated in the document, "A Policy for Biomedical Research," (*J. Med. Educ*, Vol. 46: 689-743, No. 8, August 1971). In this document, it was recommended that the administration and the Congress be urged to continue Federal programs providing fellowships and other stipends for advanced training in the health sciences and clinical specialties. More recently, the Committee on Biomedical Research has considered this matter and has recommended: That the Federal government has the responsibility to support training for research in the biomedical sciences and that the support of such training should be related to the anticipated needs, variety, quality and quantity of qualified biomedical scientists. To achieve this goal, the Committee recommends that a more formal mechanism be established to examine, on an on-going basis, both the supply and demand for biomedical scientific manpower by discipline category, with the recognition of the long-lag phase between entry into the training pipeline and the emergence of an independently competent investigator.

The Executive Council on June 21, 1974 endorsed the recommendations of the conference on Biomedical Research Manpower sponsored by the AAMC Council of Academic Societies in October 1973. The conference called for the establishment of a national commission to determine the appropriate role of the Federal government in support of biomedical research and research training.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has testified in support of training legislation, both in the House and Senate and successfully brought suit to force the expenditure of Congressionally-appropriated research training funds which had been impounded by the Executive Branch.

The National Research Council of the National Academy of Sciences has undertaken a study of biomedical research manpower requirements with the support and cooperation of the AAMC. The Association is working closely with the National Institutes of Health to oppose the reduction in support of biomedical research training, to support the NRC study and to increase stability in the research training programs by legislative testimony, dissemination of information to Congress and the medical schools, and provision of data to interested organizations. The President's Biomedical Research Panel has also been informed of the Association's view of the need for research training programs supported by the Federal government in order to assure the supply of qualified biomedical research investigators.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: WHO IS RESPONSIBLE FOR ENSURING THAT THE RIGHTS OF THE SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH ARE PROTECTED?

There is increasing public concern regarding the protection of human subjects in biomedical research. The National Research Act enacted July 12, 1974 has established a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The DHEW has modified its guidelines for biomedical research involving human subjects and is in the process of adding new regulations pertaining to the fetus, the abortus, pregnant women, children, and institutionalized subjects with limited ability to provide informed consent.

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC policy on this issue is predicated on the fact that biomedical research involving human subjects is an essential component of the process whereby new and innovative ideas are evaluated before being made available to the public as accepted modalities of health care. The Executive Council approved a policy statement in September 1972 asserting that academic medical centers have the responsibility for ensuring that all biomedical investigations conducted under their sponsorship involving human subjects are moral, ethical, and legal. The centers must have rigorous and effective procedures for reviewing prospectively all investigations involving human subjects based on the *DHEW Guidelines for the Protection of Human Subjects* as amended December 1, 1971, and formalized in *DHEW Regulations on Protection of Human Subjects*, Title 45, subtitle A, Part 46, effective July 1, 1974. Those faculty members charged with this responsibility should be assisted by lay individuals with special concern for these matters. Ensuring respect for human rights and dignity is integral to the educational responsibility of the institutions and their faculties.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has actively supported legislation directed toward the establishment of national standards for the ethical aspects of biomedical research and has participated in the revision of the Department of Health, Education and Welfare Guidelines which pertain to the Protection of Human Subjects participating in biomedical research in situations in which there are limitations on the ability of the subject to give informed consent, i.e., the child, the institutionalized mentally disabled and the prisoner.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research has been created and its deliberations have been monitored carefully by the Association. Testimony from biomedical scientists given at public hearings before the Commission was coordinated by the Association and was particularly effective. The Commission has completed hearings on the protection of subjects of fetal research and has adopted recommendations consistent with testimony given by members of the Council of Academic Societies of the Association. The Association will continue its efforts as areas other than fetal research are discussed.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: WHERE SHOULD OUR NATIONAL BIOMEDICAL RESEARCH PROGRAMS BE CONDUCTED?

During the past eight years there has been a trend toward conducting a greater portion of our Federally supported biomedical research programs in for-profit institutions and a decreasing portion in non-profit institutions, such as academic medical centers.

PRESENT STATE OF POLICY DEVELOPMENT:

The Committee on Biomedical Research and Research Training has considered this matter and has emphasized that there are finite benefits to be gained from conducting biomedical research in the same institutions in which both medical education occurs and health care is delivered. For example, scholarly activities such as biomedical research conducted by medical school faculty expose medical students to the development of new knowledge and stimulate their desire to keep abreast of new developments which will influence their later practice of medicine. Conduct of biomedical research programs in the environment in which health care is delivered stimulates the rapid transfer of innovative new ideas to the delivery of routine medical care. Thus, the Committee recommends that sponsors of biomedical research programs take maximum advantage of this unique opportunity to improve national health.

PROGRESS TOWARD ACCOMPLISHMENT:

In testimony presented to Congress on the National Cancer Act, the National Heart and Lung Act, and before both the House and Senate appropriations committees, the Association has emphasized the important role of academic medical centers in the conduct of our national biomedical research programs.

The Association has recommended to HEW officials that the President's Biomedical Research Panel, established by the National Cancer Act Amendments of 1974, be requested to examine the appropriate institutional setting for the conduct of the nation's biomedical research effort with particular attention to the locations where such effort is conducted.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: SHOULD ADDITIONAL NIH CATEGORICAL RESEARCH INSTITUTES BE ESTABLISHED? SHOULD TARGETED RESEARCH PROGRAMS BE EXPANDED?

The creation of the National Institute on Aging and the proposal of legislation designed to focus additional attention on specific disease categories (arthritis, diabetes) reflect the pressures to establish new research organizations and programs devoted to specific health problems. These proposals are designed to provide additional funding for research in the targeted area, but may, in fact, detract from the funding of other areas of research.

PRESENT STATE OF POLICY DEVELOPMENT

On September 20, 1974, the Executive Council adopted the position that an effective national biomedical research program requires an organizational structure with reasonable stability, comprised of a limited number of component entities. The potential for substantial overlap among research projects requires a high degree of coordination to assure orderly management. Such coordination will be more difficult and the administrative burdens and costs considerably greater if there is a proliferation of organizational entities. Furthermore, proposed expansions in targeted research programs must be evaluated in terms of the scientific understanding of the disease and the potential for progress through the targeted approach, the relative priority of the emphasized area in relation to on-going programs, and the need for adequate support for fundamental research.

The policy position recognizes that to accomplish new objectives it may be necessary to add responsibilities to existing programs and to intensify effort in specially designated areas, but this should be accomplished, if at all possible within the current NIH/NIMH structure.

PROGRESS TOWARD ACCOMPLISHMENT:

A key element in the past and future success of the national effort to conquer disease is a strong and balanced program of high quality biomedical research. The AAMC, therefore, in discussions with government officials and in testifying on new legislation dealing with the establishment of new research institutes or new targeted research programs, will urge that such action await the recommendations of the President's Biomedical Research Panel, mandated by the National Cancer Act Amendments of 1974 to review, assess, and make recommendations on the organization and operation of biomedical and behavioral research conducted and supported by NIH/NIMH.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training.

ISSUE: IS THERE A SHORTAGE OF PHYSICIANS IN THE UNITED STATES?

No study has ever concluded to the satisfaction of all what the number of physicians in the U.S. should be. Geographic and specialty maldistribution cause shortages and surpluses to exist simultaneously. It has been politically popular to call for more doctors without concurrent efforts to direct them to shortage areas. It has been politically untenable to say there are enough physicians without proposing some means of redistribution.

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC policy holds that any determination of the number of physicians needed must take into account the complex problems of physician distribution. The view of the 1970 Howard Committee report approved by the Assembly, (See - *J. Med. Educ*, Vol. 46:105-116, No. 2, February, 1971) that physician shortages would be met by a medical school enrollment increase to 15,000 entering students by 1975-76 is supported. This increase would give the U.S. one of the highest physician/population ratios in the world by the mid-1980's.

The impact of the recent expansion of medical school class size on the health care system should be observed and measured before the need for more physicians can be assessed.

PROGRESS TOWARD ACCOMPLISHMENT:

The goal of enrolling an entering class of 15,000 medical students by 1975-76 will most likely be met. The Association has supported programs designed to alleviate shortages by encouraging physicians to enter primary care or to practice in shortage areas. In discussions with the Congress and the Executive Branch of the Federal government, the Association has recommended that the impact of the current medical school class size on the health care system be evaluated before further expansion is required.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

ISSUE: WHAT SHOULD THE AAMC AND ITS MEMBER INSTITUTIONS DO TO REMEDY THE MALDISTRIBUTION OF PHYSICIANS AMONG SPECIALTIES?

There is a growing consensus that the pattern of specialization among physicians is inconsistent with the health care needs of the Nation. Although the precise forecasting of the numbers and types of specialists which will be needed in the future is inexact, presently, conventional wisdom concludes that considerably more generalists-specialists are needed and considerably fewer more narrow specialists are needed.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association adopted as its major emphasis during 1973 the improvement of education for primary care specialists. The Graduate Medical Education Committee has recommended that 50% of graduating medical students should become primary care specialists. This has also been endorsed by the Committee on Physician Distribution of the Coordinating Council on Medical Education. The Executive Council on September 20, 1974 approved the CCME Committee's report, which recommended that (1) medical schools should provide an appropriate environment, clinical resources, and curricula that will motivate students to select careers related to the teaching and practice of primary care; (2) institutions responsible for graduate education should establish residencies in family practice, internal medicine, and pediatrics which are oriented toward primary care and are equal in professional status with education programs in the medical and pediatric subspecialties, and (3) educational institutions should develop better methods for delivery of primary care.

The AAMC Executive Council approved a proposal for the renewal of health manpower legislation which would provide the incentive of additional capitation support to schools undertaking primary care education initiatives. The Association has also proposed that the number and distribution of accredited residency positions by specialty reflect national needs, as designated by the Secretary, HEW, and an advisory panel, with the further provision that only the designated positions be eligible for third-party reimbursement.

The Executive Council recommended that the AAMC provide a broader forum for the urgent consideration of specialty maldistribution. To this end a Plenary session at the 1974 Annual Meeting, sponsored by the Council of Academic Societies, the Council of Deans, and the Council of Teaching Hospitals addressed the issue of "Specialty Distribution of Physicians."

PROGRESS TOWARD ACCOMPLISHMENT:

In October 1974, the Association sponsored an Institute on Primary Care. The Institute was followed by a series of six regional workshops that focus on the issues and processes involved in primary care development. Through its position on institutional responsibility for graduate medical education, the Association has urged the academic medical centers to develop decision-making processes regarding the numbers and types of residency and fellowship programs they sponsor. The Association is cooperating with specialty groups seeking to determine the numbers of specialists being trained and projecting these numbers against predictions of future needs. Currently, the Association is studying the possibility of developing a feedback system to the schools so that they will be informed regarding the selections their students make for specialty training and ultimate career development.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies; Department of Health Services; Department of Academic Affairs

AAMC COMMITTEE: CCME; Task Force on Primary Care

ISSUE: WHAT SHOULD THE AAMC AND ITS MEMBER INSTITUTIONS DO TO REMEDY THE MALDISTRIBUTION OF PHYSICIANS AMONG GEOGRAPHIC AREAS?

Geographic maldistribution of physicians is a major public concern. There are complex interrelated reasons why physicians choose one particular societal and geographic setting over another in which to establish themselves. Generally, physicians are attracted to affluent communities which provide recreational and cultural opportunities compatible with their educational background and experience. Current short-term solutions for providing physician services to both metropolitan and rural shortage areas include loan-forgiveness, service-commitment scholarships, student recruitment from underserved areas, and the National Health Service Corps. There is some interest in the Congress in making Federal support for medical education contingent on mandatory service by graduates in underserved areas.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association has supported the short-term solutions for assuring the availability of health personnel for underserved communities, and has recommended that these programs be strengthened and expanded. The Association views mandatory service as an inadequate solution to the maldistribution of physicians; more appropriate solutions are the programs designed to provide students with prior exposure through community outreach programs to underserved areas, with the expectation that such exposure will affect their practice location. The Association endorses the National Health Service Scholarships and the Corps as a volunteer mechanism to provide health professional personnel and the needed infrastructure to provide care in underserved areas.

PROGRESS TOWARD ACCOMPLISHMENT:

Promoting the provision of student experiences in areas of chronic physician shortage (rural and urban inner city) has not been specifically planned, and cannot effectively be accomplished without special financial resources. Long range plans for sustaining regionalized programs are essential. The Association has supported legislation which would provide resources to enable academic medical centers to provide education and care in shortage areas, as the most promising and equitable long-term solutions to the geographic maldistribution problem. It has also supported the legislation to establish the National Health Service Corps and the appropriations to support the programs.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies; Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee

ISSUE: SHOULD ACADEMIC MEDICAL CENTERS ASSUME RESPONSIBILITY FOR DEVELOPING NEW MODES OF PROVIDING HEALTH CARE?

In the midst of the debate over national health insurance and the various approaches to improving the financing and delivery of health services, the HMO and the restructured outpatient department have emerged as possible alternative approaches toward improving health care. The problem of inefficiency of operation and inadequacy of services in the traditional OPD are well known. The university-operated OPD in particular, suffers from inadequate funding, inefficient organization, rising costs and increased workloads.

PRESENT STATE OF POLICY DEVELOPMENT:

This issue must be addressed by each constituent institution, taking into account local needs, resources and interests. Because of their unique resources, academic medical centers bring to the development of health care services the full spectrum of medical, social and behavioral sciences. The experiments of those institutions in HMO development and operation, as well as OPD restructuring could well serve as models for other academic medical centers that anticipate adopting these approaches to health care delivery.

Past AAMC testimony on health maintenance organizations has supported the request of funds for the development of academic medical center related HMOs.

PROGRESS TOWARD ACCOMPLISHMENT:

In 1972 the Department of Health Services contracted with the HMO office of HEW to assist in the development of prototype HMOs affiliated with academic medical centers. The five institutions selected to participate have received consultative support and technical assistance to develop their HMO models. Although the project will be terminated in June, 1974, the participating institutions may apply for direct Federal assistance for further planning, development and operational support.

The Department of Health Services is considering the development of a project to strengthen and upgrade university outpatient departments. The project's major emphasis will be on restructuring OPD activities into a strong academic base for primary care and on facilitating their integration with the overall institutional program. If funds are obtained, the Departmental staff will provide technical assistance and consultation to AAMC institutional members that are interested in OPD reorganization.

The prototype HMO project has made it possible for five selected academic medical centers to receive support and assistance in addressing the various critical issues attendant to the development of an HMO. A final report is now available to all interested constituent institutions.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee

ISSUE: WHAT IS THE ROLE OF THE MEDICAL SCHOOLS AND TEACHING HOSPITALS IN TEACHING HEALTH PROFESSIONALS TO WORK AS A TEAM, BETTER RELATING RESPONSIBILITY TO TRAINING?

The immediate demand for primary medical services coupled with the current geographic and specialty maldistribution of physician manpower requires alternate approaches to the health manpower shortage. Training programs for new health care practitioners such as physicians' assistants and nurse practitioners have developed partially in response to this need. In order to function effectively as a team, the new health professionals and physicians should be trained together in clinical settings which focus on their collective roles and responsibilities as member of a provider unit. Such joint interdisciplinary training has the potential for increasing the supply and effectiveness of primary care personnel for both urban and rural populations.

PRESENT STATE OF POLICY DEVELOPMENT:

Although this is an institutional responsibility dependent upon local needs and resources, the AAMC strongly encourages constituent efforts in seeking programmatic support for these activities.

It is felt that the academic medical centers might take an active role in developing common core curricula for medical students and new health practitioners which reflect a team approach to the delivery of primary health services. However, there is need for experimentation in the clinical environment to evaluate the validity of the team concept, of various approaches to organization and structure, and of the most effective means to integrate this concept into clinical education.

The Association's Health Manpower Legislation proposal, as approved by the Executive Council, supports interdisciplinary training through special project grants and capitation incentives.

PROGRESS TOWARD ACCOMPLISHMENT:

An AAMC survey in 1973 identified 69 academic medical centers currently involved in educational programs for new health practitioners. One third of these programs have students attending didactic courses with medical students and two thirds training medical students and health practitioners students together in clinical settings.

On May 1, 1974, the Department of Health Services signed a contract with BHRD to develop pilot physician training programs in HMOs, one component of which will explore the integration of training programs for physicians and new health practitioners.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee

ISSUE: SHOULD ALL AMERICANS BE GUARANTEED THE ABILITY TO PAY FOR NECESSARY MEDICAL CARE?

Because national health insurance is a high priority legislative issue with the Congress, the AAMC will increasingly be called upon to express its views regarding the scope of benefits and co-insurance and deductible features of any national health insurance program which may be proposed.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly adopted a policy on national health care in February 1971 which included the statement, "The Association of American Medical Colleges supports the concept that adequate health care and maintenance is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system. This system must be a national one, with adequate provision for varying regional requirements."

A more explicit Association policy has been developed by the Task Force on National Health Insurance and by the Executive Council. The report of the Task Force says: "A program of national health insurance is designed to provide ready financial access to the health care system and to shift the financial burden of health care from personal expenditures to insurance coverage, thus broadening the financial base available to support health care costs. The ideal health insurance program should therefore have no cost-sharing provisions. If a particular health insurance proposal includes cost-sharing mechanisms as deductibles, coinsurance, or copayments, they should be held to minimum levels, and their effect on utilization should be evaluated. They should only be high enough to avoid over-utilization; they should not be burdensome in the aggregate to a family; they should be waived for low-income persons. Furthermore, they should not be applicable to essential minimum services, and the cost of administering the cost-sharing should not exceed the savings from avoided over-utilization."

The Executive Council on June 21, 1974 approved the report of the Task Force.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC position on national health insurance has been presented to Congressional committees considering national health insurance.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of Federal Liaison; Department of Teaching Hospitals; Department of Health Services

AAMC COMMITTEE: Task Force on National Health Insurance

ISSUE: SHOULD THE METHOD OF FINANCING MEDICAL CARE DETERMINE THE ORGANIZATION OF THE DELIVERY SYSTEM?

Inherent in any debate on national health insurance is the extent to which the method of financing should be used as a mechanism to influence the organization of medical services. In the context of the overall policy question are such issues as the distribution of personnel and facilities, quality assurance, as well as the nature and scope of regulatory bodies to monitor the system.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly adopted a policy on national health care in February 1971 which included the statement, "The Association of American Medical Colleges supports the concept that adequate health care and maintenance is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system."

A more explicit Association policy has been developed by the Task Force on National Health Insurance and by the Executive Council. The report of the Task Force says, "The major purpose of national health insurance legislation, then, is to create a better means of financing medical care. Although national health insurance per se may not effect a drastic restructuring of the health care delivery system, it should promote needed changes. To define and then bring about the ideal delivery system is too great a task to be accomplished in a single step. Yet national health insurance should both permit and strongly encourage changes in the present delivery system."

The Executive Council on June 21, 1974 approved the report of the Task Force.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC position on national health insurance has been presented to Congressional committees considering national health insurance.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of Federal Liaison; Department of Teaching Hospitals; Department of Health Services

AAMC COMMITTEE: Task Force on National Health Insurance

ISSUE: WHAT IS THE RESPONSIBILITY OF ACADEMIC MEDICINE IN ADVANCING THE STATE OF THE ART OF QUALITY OF CARE ASSESMENT?

The recent PSRO legislation serves as a hallmark of the trend toward provider responsibility in assuring the quality of patient care. The issue of quality is one that is closely related to access. Above and beyond the availability of health services, there is the need to assess objectively the level and quality of care that is provided.

PRESENT STATE OF POLICY DEVELOPMENT:

In March 1973, the Executive Council approved 5 propositions directed toward a new thrust in continuing education. The second of these propositions was, "Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm."

The AAMC believes that the academic medical center is in a unique position to undertake the tasks of developing feasible quality assessment tools, criteria and standards of measurement, and of implementing quality assurance mechanisms.

PROGRESS TOWARD ACCOMPLISHMENT:

The Departmental staff is now in the process of exploring with DHEW the possibility of a collaborative project with a selected number of academic medical centers in order to test and validate various approaches to the development of medical care criteria and outcome assessment. This is projected as a one-to two-year study to be coordinated through the Department of Health Services.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee/Subcommittee on Quality of Care

ISSUE: HOW SHOULD HOSPITAL COSTS BE CONTROLLED?

Final regulations implementing Section 223 of P.L. 92-603 limiting Medicare reimbursement for per diem routine service costs for similar groups of hospitals were issued May 30, 1975. These regulations supersede interim regulations issued June 6, 1974. The interim regulations grouped all short-term hospitals in the United States into 70 groups based upon: (1) Number of adult and pediatric beds (7 categories); (2) State per capita income grouping (5 categories); and (3) Metropolitan area designation (2 categories). Reimbursement within each group was set at the 90th percentile plus ten percent of the median. Under the final regulations hospitals have been divided into 32 groups based on the same variables as in the interim regulation. However, bed size has been reduced to four categories for urban hospitals and three categories for rural hospitals. Per capita income rankings are now based upon SMSA designations instead of by state. Reimbursement under the final regulation is limited to the 80th percentile plus 10 percent of the median for each group.

The present hospital classification scheme employed in implementing the regulation, as in the interim regulations, fails to account for case mix or the nature of facilities and services provided. As such, hospitals producing different types of products are grouped together for cost comparison purposes. Teaching hospitals having a complex case mix and providing a wide variety of tertiary services and facilities are compared with hospitals having less complex case mixes and providing a more limited array of services.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association's position is that by not accounting for case mix and the nature of facilities and services offered, the Social Security Administration has developed a classification scheme that will deny reimbursement for costs that are, in every way, reasonable. Thus the present classification scheme provides no assurance that hospital costs exceeding the limits flow from hospital inefficiency. There is an equal probability that cost differentials result from legitimate product differences. According to a staff estimate, 40 percent of the membership of the Council of Teaching Hospitals will have costs exceeding the published limits.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has tried over the past year to work with SSA in developing an equitable hospital classification methodology. Publication of final regulations May 30, 1975 is evidence of the failure of this effort. Consequently the Association has instituted legal proceedings to have the new regulations declared illegal and invalid.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Teaching Hospitals

AAMC COMMITTEE: Ad Hoc Committee on Section 223

ISSUES, POLICIES, PROGRAMS

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ISSUE: HOW AND BY WHOM SHOULD ACCEPTABLE QUALITATIVE LEVELS OF EDUCATIONAL PROGRAMS BE ASSURED?

PRESENT STATE OF POLICY DEVELOPMENT:

The primary responsibility for assuring that educational programs are of acceptable quality rests with each institution. It is a responsibility borne primarily by its faculty exercising its collective academic judgment in the design and implementation of the curriculum, the assignment of competent educators, the selection of capable students and the evaluation of their performance. The institution is assisted in gauging its own performance through the availability of external assessment procedures and instruments.

Accreditation of institutions and education programs is the primary instrument developed by the institutions and the professions as a means of external review, monitoring and assessment of the institutional or program quality. As it has evolved, accreditation brings to bear the disinterested expert judgment of outside professionals and academicians, leavened by the perspective of informed public representatives. Its purpose is to assure the institution that its resources are adequate to serve its objectives and directed toward their achievement, to assure applicants and students that their education can be successfully pursued in the institution, and to assure society that its resources are appropriately utilized and the graduates of the institution are qualified according to their credentials.

The AAMC Assembly approved the revised "Function and Structure of a Medical School" in 1972, setting forth the criteria to be used in the accreditation of medical schools.

PROGRESS TOWARD ACCOMPLISHMENT:

Two parallel efforts are underway to achieve the purposes and objectives of accreditation as a guarantor of educational program quality. The first is directed toward refining the sophistication of the process of accreditation; it involves the development of more appropriate organizational forms — the formation of the CCME, the LCGME and progress toward an LCCME to complement the role and function of the LCME — the refinement of the accreditation standards — the *Function and Structure of a Medical School*, the *Criteria for Programs in the Basic Medical Sciences* — the development of more appropriate assessment procedures and instruments — the exploration of the use of the self study protocol, the refinement of data collection instruments.

The second involves defining the integrity of voluntary accreditation from encroachment and dismantlement by the Federal government and zealous critics of the system. This has entailed a review, critique and negotiations for revisions in the OE draft Criteria for Recognized Accrediting Agencies, comments on the SASHEP Report, review and comment on the Newman Report, "National Policy and Higher Education," and the Brookings Institution (Orlans) report, "Private Accreditation and Public Eligibility."

AAMC DEPARTMENT PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE: LCME, LCGME, CCME (AAMC participates in these conjoint committees)

ISSUE: SHOULD THERE BE A NATIONAL EXAMINATION REQUIRED FOR ALL STUDENTS AT THE INTER-FACE BETWEEN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION?

Entrance into graduate medical education for U.S. medical students has only required the satisfactory completion of a course of study and the awarding of an M.D. degree by an accredited medical school. Although some graduate medical institutions and some states have required that residents be licensed and thus have required the passing of a licensing exam such as the NBME exam, the FLEX exam or state licensing board exam, there has been no uniform, national requirement for all students who enter graduate medical education to pass a qualifying exam.

PRESENT STATE OF POLICY DEVELOPMENT:

The Executive Council approved the report of the Task Force on Foreign Medical Graduates which recommends "... that a generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the National Board Examination or the FLEX examination should be required."

The National Board of Medical Examiners established a Committee on Goals and Priorities in 1971. The Committee report entitled, "Evaluation in the Continuum of Medical Education," was released in June 1973. This report recommends the development of a qualifying exam required for all who enter graduate medical education in the United States whether they have received their M.D. degree from a domestic or foreign school. This report was received by the NBME and has been under intense study during the subsequent 10 months. The NBME does not plan immediate implementation.

The Executive Council has established a Task Force to analyze the Goals and Priorities Committee report and recommend to the Executive Council a position on this issue.

PROGRESS TOWARD ACCOMPLISHMENT:

The FMG Task Force report has been distributed to the constituency for reaction and comments.

The Task Force on the GAP Report will report to the Executive Council in the Fall of 1974. In December of 1973, a committee requested by the Group on Medical Education to explore the reactions of the schools and the faculties to the GAP Report was convened. This committee held meetings in all four regions and has produced a set of working papers which will be utilized by the Task Force in analyzing the GAP Committee report. There are numerous position statements and resolutions which have been received by the Association from medical schools and from academic societies. All of these communications are being collated and will be utilized by the Task Force.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs; Department of Institutional Development

AAMC COMMITTEE: FMG Task Force – discharged; Ad Hoc Task Force on the NBME-GAP Report; CCME

ISSUE: SHOULD THE AAMC ASSIST MEDICAL SCHOOL FACULTIES IN IMPROVING THEIR CAPACITIES TO MEET THEIR GROWING EDUCATIONAL COMMITMENTS?

This is a time when faculty members in our medical schools are being called upon to educate increasing numbers of students, without comparably increased numbers of faculty or enlarged resources, while assuring that there is, at the very least, no decrease in the quality of the educational product. At the same time, it is being increasingly recognized that although instruction is the primary responsibility of medical school faculty members, it is the responsibility for which they are least prepared.

PRESENT STATE OF POLICY DEVELOPMENT:

Until the present, the AAMC has done little, if anything, in the area of direct assistance to faculty in the improvement of their capacity as instructors. In March 1974, the decision was made to establish a new Division of Faculty Development, which began to function on September 1, 1974. It is the responsibility of this Division to devise methods and develop services which will assist faculty members of medical schools in improving their effectiveness as teachers, and in the efficient use of their instructional time.

PROGRESS TOWARD ACCOMPLISHMENT:

A Director for the Division of Faculty Development has been appointed, a basic budget for the establishment of this new unit has been secured, and funding proposals are being prepared for submission to foundations and agencies. As soon as funding is assured, active recruitment will be undertaken for additional staff for this Division.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Faculty Development

AAMC COMMITTEE:

ISSUE: SHOULD THE AAMC PLAY AN ACTIVE ROLE IN IMPROVING THE ACCESSIBILITY AND EFFECTIVE USE OF MULTI-MEDIA EDUCATIONAL RESOURCES?

The increasing development of educational technologies has provided an ever increasing universe of multi-media learning materials to assist medical school faculties in their teaching of increasing numbers of students. These same technologies have provided students with an opportunity to better realize a more individualized medical curriculum and to enhance the development of their skills in self-education, self-evaluation and communication. Problems relating to the use of multi-media educational material include: the absence of an efficient clearinghouse for evaluated materials; the availability and shareability of these materials by institutions and subject areas of perceived need; the varying abilities of faculties and students to utilize these materials effectively and the irregular patterns of quality and cost.

PRESENT STATE OF POLICY DEVELOPMENT:

A workshop was held February 1969 entitled "Potential Educational Services From a National Biomedical Communications Network." Subsequently, the AAMC Biomedical Communications Network Steering Committee was established in 1969. A series of recommendations was presented to both the NLM and the academic community defining the roles and responsibilities of both the academic community and the Federal government in enhancing the uses of educational technology in medical education. Reports were published as supplements to the *Journal of Medical Education*: Educational Technology for Medicine: Roles for the Lister Hill Center (*J. Med. Educ.*, Vol. 46: July (Part 2) 1971) and Educational Technology for Medicine: Academic Institutions and Program Management (*J. Med. Educ.*, Vol. 48: 203-226, No. 2, February 1973).

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC Division of Educational Resources was established in 1973. A contract from NLM permitted the initiation of the AAMC/AADS Educational Materials Project. The five basic programs include: the development of a system for the appraisal of educational materials in nontraditional formats (audiovisual, computer-based instruction, simulations, etc.); the development and implementation of a clearinghouse system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by students and faculties; and other areas of mutual concern regarding the uses of educational technology in health science education. A grant from the Kaiser Family Foundation and Commonwealth Fund has permitted a feasibility study to explore the development of a national institutional model to enhance the use and effectiveness of multi-media learning systems.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Educational Resources

AAMC COMMITTEE: AAMC/AADS Educational Materials Project Advisory; Kaiser/Commonwealth Feasibility Study Advisory Panel

ISSUE: SHOULD CLINICAL EDUCATIONAL PROGRAMS IN DIVERSIFIED SETTINGS BE ENCOURAGED?

The ambulatory care function of the academic medical center takes place in a variety of settings, the most universal of which are outpatient departments and emergency services. Others include neighborhood health centers, C and Y clinics, group practices and HMO's. Settings in which quality primary care is delivered are considered to be appropriate sites for primary care training programs. To meet the increased need for appropriate primary care, academic medical center faculty involved in the delivery of primary care must integrate ambulatory service and teaching into effective training programs.

PRESENT STATE OF POLICY DEVELOPMENT:

The Functions and Structure of a Medical School, prepared by the LCME and ratified by the Assembly in November 1972, states, "Instruction should be sufficiently comprehensive so as to include the study of both mental and physical disease in patients who are hospitalized as well as *ambulatory*."

AAMC testimony on area health education centers and health maintenance organizations has requested support for the development of physician training programs in a variety of organizational frameworks and different health care facilities.

PROGRESS TOWARD ACCOMPLISHMENT:

A survey of the schools in 1973 revealed that undergraduate students have on the average only 2 months of clinical experience in ambulatory settings. Beginning May 1, 1974, through a contract with the Bureau of Health Resources Development, a pilot program to develop physician training programs in HMO's will be started.

A second proposal was submitted to BHRD in March 1974 which outlined a two-and-a-half-year project to assist academic medical centers in developing, implementing and evaluating primary care training programs in a variety of ambulatory settings at both the graduate and undergraduate levels. The project will involve 4-6 constituent institutions and will attempt to determine the cost effectiveness of the different training programs.

A Primary Care Institute will be held in October 1974. Its focus will be on the organization of optimum settings for primary care training programs. This three-day invitational conference will be attended by deans and chairmen of medicine, pediatrics, family medicine and others.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Task Force on Primary Care

ISSUE: SHOULD THE AAMC ENCOURAGE THE INVOLVEMENT OF UNITED STATES MEDICAL SCHOOLS IN INTERNATIONAL HEALTH?

United States medical schools with the assistance of AAMC are making serious efforts to develop community medicine and primary care as major academic programs. Opportunities for experience in international health may be an important adjunct to this effort. If an experience abroad is well-planned, it can impress on the student the responsibilities of the physician in developing comprehensive community and personal health services.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association established and maintains a Division of International Medical Education to encourage and assist medical schools in becoming more involved in international health.

PROGRESS TOWARD ACCOMPLISHMENT:

Many schools conduct education programs in international health offering senior students a one to three month experience abroad. AAMC also has administered a national fellowship program for medical students in collaboration with Israeli and Yugoslav faculty. In view of the widespread activities and interests, general guidelines entitled, "Essentials of Programs for Education in International Health," for the planning and administration for such programs are under preparation. It is proposed that the educational sequence outlined in these "Essentials" may be acceptable in total or in part as an adjunct to education programs in community medicine and primary care.

In addition, the AAMC maintains contact with the Liaison Officers for International Activities at each medical school, and assists them wherever possible. Through the Association, deans and faculty members have been actively involved in the Pan American Federation of Associations of Medical Schools, the Association of Medical Schools of Africa, and related international activities.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of International Medical Education

AAMC COMMITTEE: Committee on International Relations in Medical Education and an advisory group chosen from the Liaison Officers for International Activities

ISSUE: SHOULD THE MEDICAL SCHOOLS ASSUME INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS OF GRADUATE MEDICAL EDUCATION?

The medical schools have increasingly become engaged with graduate medical education, and most schools have as many or more interns or residents as they have undergraduate medical students. However, the responsibility and authority for these programs is divided among the many department heads in the clinical disciplines and is further divided among the several hospitals which make up most academic medical centers. The issue revolves around having the academic medical centers develop systems which make the entire faculty responsible for graduate medical education and provide for overall administration of graduate programs by the academic medical centers' administrative teams. The dean of the medical school would thus have a far greater role in planning and developing graduate programs for residents.

PRESENT STATE OF POLICY DEVELOPMENT:

By action of the Assembly in 1971, a position statement (published in *AAMC Bulletin*, Nov. 15, 1971) recommends that the academic medical centers assume responsibility for graduate medical education in a fashion analogous to that for which they have responsibility for undergraduate medical education. This implies that the faculty of the institutions as a whole should assume responsibility for planning and evaluating the graduate programs of instruction and should set the standards for student selection, progress and certification for readiness to be examined by specialty boards. The program further recommends that freestanding hospitals desiring to continue or develop graduate medical education programs should seek affiliation with university academic centers or should develop sufficient resources to permit their being accredited as freestanding graduate medical schools. This position statement was evolved subsequent to a conference of the Council of Academic Societies in 1968; the proceedings were published as a special issue of the *Journal of Medical Education* (*J. Med. Educ.*, Vol. 44: September (Special Issue) 1969). A committee chaired by Thomas D. Kinney published the IMPLICATIONS document (*J. Med. Educ.*, Vol. 44: 77-84, No. 2, February 1972).

PROGRESS TOWARD ACCOMPLISHMENT:

The Graduate Medical Education Committee, chaired by William G. Anlyan published a supplement to the *Journal of Medical Education*, entitled "*Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education*" (*J. Med. Educ.*, Vol. 48: 780-791, No. 8, August 1973). There has been a heavy reprint demand for this document and many schools have indicated that they are having faculty retreats and administrative discussions regarding plans for increasing institutional responsibility for graduate education. A few institutions have developed proposals which are under active discussion. A major problem regarding moving toward assuming institutional responsibility is the issue of how to finance graduate medical education, the CCME has adopted a statement which incorporated the principal recommendations of the AAMC position statement; the Executive Council ratified the CCME statement.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs; Division of Student Studies

AAMC COMMITTEE: Graduate Medical Education Committee

ISSUE: SHOULD ACCREDITATION OR OTHER EXTERNAL MECHANISMS BE USED TO REGULATE THE NUMBER AND DISTRIBUTION OF RESIDENCY POSITIONS?

Residency and fellowship positions in the specialties and subspecialties have never been subject to quantitative controls. The number of programs currently existing is a result of multiple independent decisions by hospitals and program directors. The Boards and the Residency Review Committees have no policies relating to the number of specialty programs in the United States.

PRESENT STATE OF POLICY DEVELOPMENT:

One of the implications of the institutional responsibility statement is that the institutions should assume responsibility for determining both the types of residency and fellowship programs they will sponsor and the number of students they will enroll. The Graduate Medical Education Committee recommended in its informational report to the Executive Council in December 1973 that the schools and graduate programs should set a goal of enrolling and retaining 50% of graduating medical students in the primary care specialties of family medicine, general medicine and general pediatrics. The issue of using the accreditation mechanism for limiting the number of graduate programs has been discussed informally at several levels, including the CCME's *Ad Hoc* Committee on Physician Distribution.

In March 1974, the Executive Council approved the FMG Task Force Report which recommended "... that the number of first year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools, but provide sufficient opportunities to highly qualified FMG's."

PROGRESS TOWARD ACCOMPLISHMENT:

The CCME *Ad Hoc* Committee on Physician Distribution will report to the CCME sometime during 1974. It is anticipated that this report will recommend that at least 50% of graduating students from U.S. medical schools should be retained in primary care specialties, but it is unlikely that a firm recommendation that a national system for determining the number of residency positions in any specialty will be specified. The Liaison Committee on Graduate Medical Education, as it reviews the quality of the Residency Review Committees' actions, may exert sufficient influence to decrease the number of training programs by eliminating those that are particularly weak. The Graduate Medical Education Committee of the AAMC is continuing to study this issue and has adopted the stance that the total number of graduate medical education positions in the U.S. should be limited to a number in the range of 110 to 120% of the graduating class. Recommendations for how to accomplish this goal have not yet been developed.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs; Department of Institutional Development

AAMC COMMITTEE: Graduate Medical Education Committee; LCGME, CCME (AAMC participates in these conjoint committees)

ISSUE: HOW SHOULD GRADUATES OF FOREIGN MEDICAL SCHOOLS BE INTEGRATED INTO UNITED STATES PROGRAMS OF GRADUATE MEDICAL EDUCATION AND INTO THE UNITED STATES HEALTH CARE SYSTEM?

In 1972 one third of all enrolled interns and residents in United States teaching hospitals and 49 percent of all physicians receiving state licenses to practice medicine were graduates of foreign medical schools. This disproportionate representation of FMG's represents a threat to quality education and services.

PRESENT STATE OF POLICY DEVELOPMENT:

The FMG Task Force of the AAMC in a report approved by the Executive Council made the following policy recommendations:

1. A generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the National Board Examination or the FLEX Examination should be required.
2. Pilot programs with enrolled FMG's should explore their educational defects and ways to correct them.
3. The approval of hospital programs for graduate medical education should be based on sound educational principles and the number of positions available should not exceed to any great extent the number of graduates from United States medical schools.
4. The permanent employment of unqualified, unlicensed FMG's should be discontinued even in the institutional setting.
5. Pilot programs should explore the substitution of other means to render services presently provided by FMG's in graduate education programs.

PROGRESS TOWARD ACCOMPLISHMENT:

The Executive Council approved the FMG Task Force recommendations, and they have been submitted to the AAMC constituency for reaction and comments. Ultimate implementation will depend on constituency interest and participation. The FMG Task Force report has been published as a supplement to the *J. Med. Educ.*, vol. 49, No. 8, August, 1974.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Division of International Medical Education

AAMC COMMITTEE: FMG Task Force — discharged

ISSUE: WHAT SHOULD THE ROLE OF THE AAMC BE IN ENSURING THE VIABILITY AND INTEGRITY OF THE NIRMP?

The NIRMP was established in the early 50's to eliminate an increasingly chaotic competition for first-year graduate training positions. The elimination of an internship as a requirement for certain specialty residencies in the early 70's has resulted in multiple evasions of the program by both program directors and students. The problems are summarized in the article by Joseph Ceithaml, Ph.D., and Davis G. Johnson, Ph.D., "The NIRMP and Its Current Problems" (*J. Med. Educ.*, vol. 48: 625-629, No. 7, July 1973).

PRESENT STATE OF POLICY DEVELOPMENT:

In 1972 the COD and CAS Administrative Boards expressed concern over NIRMP violations and adopted a statement which was approved by the Executive Council. It stated: "Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, the first hospital based graduate training appointment after the awarding of the M.D. degree should be through the National Intern and Resident Matching Program."

At the request of the Organization of Student Representatives and the Group on Student Affairs, an NIRMP Monitoring Program was approved by the Executive Council in June 1973. Announcement of the program was made in Deans Memo # 74-7, February 1974. This program provides for reporting violations of the NIRMP to program directors through the office of the AAMC President, and the ultimate reporting of continuing violations to the NIRMP. The Administrative Board of the CAS has recommended the establishment of a Task Force to study NIRMP problems.

The Association, at every opportunity, has expressed its strong commitment to the viability and integrity of the NIRMP.

PROGRESS TOWARD ACCOMPLISHMENT:

AAMC staff have met with representatives of the American University Professors of Ophthalmology and with the American Association of Chairmen of Departments of Psychiatry to identify the basic reasons for the difficulty which these specialty groups have encountered with the NIRMP.

Functional problems in data processing by NIRMP staff have been resolved. The problem of enforcing adherence to NIRMP rules by program directors, hospitals and students is not resolved. The Monitoring Program may be of value, but this cannot be determined until the 1974-75 cycle. The LCGME has established an *ad hoc* committee to study the issues.

The AAMC President, Dr. Cooper, has accepted the Presidency of the NIRMP for 1974-75, and is committed to improving both the operational and the programmatic integrity of the NIRMP.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs

AAMC COMMITTEE:

ISSUE: WHAT IS THE APPROPRIATE ROLE OF THE MEDICAL SCHOOLS IN PROVIDING EFFECTIVE PROGRAMS OF CONTINUING MEDICAL EDUCATION?

Whether sponsored by medical schools, state or county medical societies or national specialty organizations, programs in continuing medical education for practicing physicians rely heavily upon the talents of the faculties of the Nation's medical schools. Because the demand for continuing medical education is rising, it is important that the faculty effort dedicated to this endeavor be as effective as possible.

PRESENT STATE OF POLICY DEVELOPMENT:

In March of 1973, the Executive Council of the AAMC adopted five propositions as the basis for developing a new thrust in continuing education. These were published in Vol. 8, No. 3, of the March 1973 issue of the *AAMC Bulletin*. The propositions are: 1. Medical faculties have a responsibility to impress upon students that the process of self education is continuous. 2. Medical faculties must cooperate with practicing physicians to develop criteria of optimal clinical management of patient problems. 3. Educational programs must be specifically directed toward improving detected deficiencies. 4. Evaluation of the effect of educational programs should be planned from their inception and should be based upon assessment of the modifications of the physician's day-to-day practice. 5. Financing of continuing education must be based upon a policy which recognizes its essential contribution to the progressive improvement of health care delivery. The Executive Council further recommended that the Group on Medical Education of the AAMC include within its members individuals from the medical schools who have responsibility for continuing medical education.

PROGRESS TOWARD ACCOMPLISHMENT:

The Group on Medical Education has been studying how to incorporate within its membership individuals from the medical schools responsible for continuing medical education.

At the time of the formation of the Liaison Committee on Continuing Medical Education (a committee under the CCME), the Association insisted that the purpose of this Liaison Committee should first be to provide a body for developing new principles and policies for continuing medical education, its supervision and accreditation. It is anticipated that the LCCME will be activated early in 1975.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs

AAMC COMMITTEE: CCME

ISSUE: SHOULD PERIODIC RECERTIFICATION AND RELICENSURE OF PHYSICIANS BE REQUIRED?

During the last five years, there has been an increasing interest by specialty boards and state licensing boards in the concept of requiring that physicians be periodically recertified or relicensed. Recertification or relicensure are generally conceived to be based upon evidence that the physician has participated in continuing education or passed an examination or both. There appears to be a consensus that recertification or relicensure requirements will improve the quality of medical care delivered, even though there is little or no evidence that this will be an outcome of such requirements.

PRESENT STATE OF POLICY DEVELOPMENT:

A preliminary draft of a position was reviewed by the Graduate Medical Education Committee in early March 1974. The Committee requested that further investigation be done regarding the potential effects of recertification on the day-to-day practice of medicine by physicians. The Committee is also concerned that should recertification and/or relicensure become a commonplace requirement, the demand for educational services from physicians now in practice may increase enormously; and such an increase will require that appropriate planning for expanding educational resources in this country will be needed.

The Graduate Medical Education Committee will study this issue during the Spring and Summer of 1974. It has been determined that twenty-two of the twenty-three specialty boards are seriously considering recertification and that two states have already adopted laws requiring relicensure. The American Board of Internal Medicine is offering a voluntary recertification exam in the Fall of 1974; the American Board of Family Practice will require a recertification of all its diplomates in 1976; the Board of Ophthalmology is considering a voluntary, self-assessment exam in 1975 as is the Board of Thoracic Surgery; the American Board of Surgery plans mandatory recertification for all those certified after September 1, 1975, on a ten-year cycle.

PROGRESS TOWARD ACCOMPLISHMENT:

Efforts to identify methodologies to assess competence are going on in several quarters, including the AAMC's Division of Educational Measurement and Research and National Board of Medical Examiners. All bodies currently concerned with recertification are uncomfortable with basing recertification solely upon passing a cognitive examination.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Educational Measurement & Research

AAMC COMMITTEE: Graduate Medical Education Committee

ISSUE: SHOULD THE AAMC ASSIST THE MEDICAL SCHOOLS IN STRENGTHENING THEIR CAPABILITY FOR DEALING WITH MATTERS THAT ARE CONSIDERED ORGANIZATIONAL MANAGEMENT PROBLEMS?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC responded affirmatively to this issue in 1971 and, with the guidance of representatives of the Council of Deans, set about to identify needs in this area and design specific programs in response. This effort was endorsed by the December, 1972 AAMC Officer's Retreat and the Executive Council.

PROGRESS TOWARD ACCOMPLISHMENT:

Three specific programs have been implemented:

1. The Management Advancement Program

Executive Development Seminar (Phase I)
Institutional Development Seminars (Phase II and III)

As of August 1974 there will have been 105 deans who have participated in Phase I; 37 schools have participated in Phase II; the first Phase III Seminar was held in June 1974 and 7 institutions attended. Future Executive and Institutional Development Seminars are being scheduled at regular intervals. A second Robert Wood Johnson Foundation grant which provides program support for an additional three years was announced this spring.

2. Institutional Studies

This effort involves the study and analysis of the common body of law and practice in the medical schools relative to institutional organization, governance and management. The delineation of areas being studied is related closely to the kinds of questions asked by the constituency: medical school/center organizational models, analysis of patterns of governance, and trends in medical school management are the types of general categories covered. These studies are supported under contract with BHRD.

3. Management Systems Development

This effort involves an exploration of the "state of the art" of management systems utilization in the medical schools and the means by which the AAMC might enhance management effectiveness through facilitating the development of more refined or appropriate instruments.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development; Department of Program Planning and Policy Development

AAMC COMMITTEE: Management Advancement Program Steering Committee; Management Systems Development Liaison Committee; Management Program Coordinating Committee

ISSUE: WHAT FEDERAL, STATE AND PRIVATE SOURCES OF FINANCIAL ASSISTANCE SHOULD BE AVAILABLE TO STUDENTS?

Financial aid to medical students is becoming a major issue; rising tuition charges and increases in the cost of living are placing severe demands upon the resources available for financial aid. Coupled with this stress is a developing attitude, particularly in the Federal government, that the cost of higher education and particularly medical education should principally be borne by the students who ultimately benefit through increased income potential during their working years.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly in 1970 passed an equal opportunity resolution. Contained in this resolution is the recommendation that the Association and the schools design programs to eliminate economic barriers to education in the health professions.

The Association has assumed the position that a principle resource for student financial aid should be the Federal government provided through the Health Professions Education Act. The Executive Council, at its December 1974 meeting, adopted the recommendations of the *ad hoc* Committee on Health Manpower, recommending that the 1974 HPEA should provide for an increase in the loan ceiling from \$3,500 to \$4,500 per student, per year and should authorize appropriations of 75 to 80 million dollars for this purpose. Health professions scholarship ceilings should be increased from \$3,500 to \$4,500 per student, per year with an entitlement formula providing for sufficient funds so that each institution may meet the needs of low-income students in its classes. It was also recommended that the National Health Service Corp Scholarship Program provide for \$6,000 per student, per year and require two years of service in a designated area regardless of the time support was received during undergraduate education.

The Association has no position on the specific obligations of states for the provision of financial aid to medical students.

Various types of loan and scholarship funds from private sources have been studied by committees of the Group on Student Affairs, including the educational opportunity bank concept; but an Association position on a specific program has not been developed.

PROGRESS TOWARD ACCOMPLISHMENT:

The Financial Aid Committee of the Group on Student Affairs and the Committee on Student Information Systems is now expanding the data base regarding the needs for financial aid among medical students. Workshops directed toward improving the management of financial aid offices in the medical schools and increasing the knowledge of financial aid officers regarding sources of funds are being held during the year 1974 in all four regions.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs

AAMC COMMITTEE: GSA Financial Problems of Medical Students

ISSUE: SHOULD MEDICAL SCHOOL ADMISSIONS BE ADMINISTERED THROUGH A NATIONAL MATCHING PROGRAM?

The increasing number of applications to medical schools has made it more and more difficult to operate the selection system for medicine in a fashion which provides an optimal opportunity for both the students and institutions to make decisions which are satisfactory to both parties. The successful experience with the National Intern and Resident Matching Plan has led many to suggest that a matching plan for admission to medical schools should be instituted.

PRESENT STATE OF POLICY DEVELOPMENT:

On November 3, 1972, the Council of Deans adopted the report of the AAMC Committee on Medical School Admissions Problems together with a recommendation from the COD Administrative Board that "the Association President and appropriate staff explore all aspects of the feasibility of a medical school admissions matching program."

PROGRESS TOWARD ACCOMPLISHMENT:

A technical study, which indicated that matching is theoretically feasible, was completed in March 1973. The medical schools in California and Michigan agreed to participate in a pilot implementation of an admissions matching program, to be conducted with the selection of the 1974-75 entering class. The program is jointly sponsored by AAMC and a grant from the Henry J. Kaiser Family Foundation. In December and January, student rank order lists were mailed to the almost 16,000 individuals who had applied to at least one participating school. In mid-April, participating schools submitted rank order lists of students. The success of computer matching will be analyzed during the fall and winter 1974. Further plans for trial matching will depend upon this analysis.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs

AAMC COMMITTEE: *Ad Hoc* Steering Committee on the Pilot Implementation of a Medical School Admissions Matching Plan

ISSUE: SHOULD SELECTION FACTORS FOR ADMISSION TO MEDICAL SCHOOL INCLUDE CRITERIA OTHER THAN ACADEMIC PERFORMANCE?

Career choice should be understood to embrace such outcomes as area of specialization and practice location. The issue raises something of a dilemma. There has long been public agreement that access to a medical education should be limited to those who are academically qualified. More recently, special opportunities for access to medical education have been afforded to underrepresented minorities. Providing special opportunities to those with personal characteristics which are estimated to influence ultimate career choice and professional performance, adds another dimension to selection decisions and may further modify the established tradition of accepting only the most intellectually qualified.

However, society's demand for greater accessibility to health care may necessitate trials of selection factors related to predicting career choice. A rational decision as to whether to introduce consideration of likely career outcomes in admissions decisions will rest on well documented, empirical evidence demonstrating the reliability of such criteria.

PRESENT STATE OF POLICY DEVELOPMENT:

The selection of students for admission to medical school is and must remain the responsibility of the faculty of each institution. Within this framework, the AAMC assists the institutions in identifying criteria which might influence admissions decisions. In an *amicus curiae* brief filed in the case of *DeFunis v. Odegaard* (U.S. Supreme Court, No. 73-235), the AAMC contended that quantitative predictors of academic performance should not be the sole criteria for admission.

The Medical College Admission Assessment Program Task Force and the Group on Student Affairs have addressed this question. Current AAMC activity involved the preparation of the data base necessary for a rational decision. This activity takes the form of an analysis of the MCAT Questionnaire data which includes career choice information and a follow-up of the AAMC Longitudinal Study of the Class of 1960.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association is seeking support for a program to follow-up the Longitudinal Study, correlating measurable characteristics with ultimate career performance. An ad hoc Committee has been appointed by the Executive Council to review the recommendations of the MCAAP Task Force and to determine priorities for their implementation.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/ Division of Educational Measurement and Research/ Division of Student Studies

AAMC COMMITTEE: *Ad Hoc* Longitudinal Study Advisory Committee; *Ad Hoc* MCAAP Review Committee

ISSUE: WHAT SHOULD BE THE NATIONAL GOAL IN EDUCATING MINORITY STUDENTS IN MEDICINE?

Students from certain minority groups in the United States have been significantly under-represented in medicine. These groups include Black-Americans, Spanish-Americans, American Indians and Puerto Ricans. As a result of the nationwide concerns regarding minority opportunities which developed during the 1960's, major efforts have been developed to increase the opportunities for students from these minority groups to study medicine.

PRESENT STATE OF POLICY DEVELOPMENT:

In May of 1970, the Executive Council accepted the AAMC Task Force Report to the Interassociation Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students. In December 1970, the Executive Council approved a policy statement calling for a short-term objective of increasing minority enrollment to 12% by the year 1975-76 in the Nation's medical schools. The policy statement also recommended the development of minority affairs offices in the medical schools and an expanded minority office at the Association. The policy statement recommended that medical school curricula should be modified to adapt to the differences in preparation of minority students in the traditional sciences and that financial constraints for minority students should be minimized.

PROGRESS TOWARD ACCOMPLISHMENT:

The Office of Minority Affairs, which was established at the Association, has published a Medical Minority Applicant Registry (MED-MAR) and "Minority Student Opportunities in U.S. Medical Schools." Both of these publications have been directed toward identifying those minority students seeking medical careers and medical schools seeking students from minority groups. Through an OEO grant, special programs directed toward recruiting and retaining minority students in the health professions were supported in various institutions in the United States.

Workshops directed toward improving selection systems for minority students and assisting schools in meeting the particular cultural and educational needs of minority students have been held in all four regions. A simulated admissions exercise system is being developed for utilization by admissions committees to improve their identification of specific variables pertinent to the selection of minority group applicants.

Minority group enrollment in first-year medical school classes was 4.8 percent in 1969-70, 7.0 percent in 1970-71, 8.6 percent in 1971-72, 8.6 percent in 1972-73 and 9.2 percent in 1973-74.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Student Programs; Office of Minority Affairs

AAMC COMMITTEE: GSA Committee on Medical Education of Minority Group Students

ISSUE: SHOULD MORE WOMEN BE ENCOURAGED TO ENTER THE MEDICAL PROFESSION?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC has clearly enunciated a policy of no discrimination in admission of students to medical school and in employment on the basis of sex. It has not, however, advanced a policy that more women should be encouraged to enter the medical profession.

PROGRESS TOWARD ACCOMPLISHMENT:

In response to the numerous requests for information about women in medicine from students, faculty, medical school administrators and professional and scientific organizations, the AAMC is attempting to organize data available on this subject. Drawing on the existing and extensive AAMC sources, including Student Information, Faculty Profile Studies, the Longitudinal Study, etc., we have attempted to coordinate the pooling of information pertaining to women in medicine. A special effort has been made to gather information from a wide variety of sources outside the AAMC and to represent the AAMC to the extent possible on an ad hoc basis at meetings and conferences which deal in a significant and relevant way with the subject of women in medicine.

Additionally, the Association will focus on the special problems encountered by women who choose medicine as a career and, for example, has established a Staff Task Force on Affirmative Action to develop means by which the AAMC might assist schools in meeting requirements for affirmative action.

An office focused on Women in Medicine has been approved in principle and staffed on a collateral duty basis, but has not been formalized organizationally. A project has been outlined which would bring to bear considerable knowledge and expertise about the question posed by this issue. This was being discussed with the Radcliffe Institute as a joint project and planning funds were sought from foundations, but without success. The press of other work has precluded additional effort directed toward raising the funds for the policy development effort or any full time staff.

The enrollment of women in first-year medical school classes was 9.1 percent in 1969-70, 11.1 percent in 1970-71, 13.7 percent in 1971-72, 16.8 percent in 1972-73, and 19.7 percent in 1973-74.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE:

ISSUE: DOES THE AAMC OR ITS MEMBER INSTITUTIONS HAVE AN OBLIGATION TO FACILITATE THE CAREER DEVELOPMENT OF U.S. CITIZENS STUDYING MEDICINE ABROAD?

It is estimated that there are between four and six thousand United States citizens studying in medical schools abroad. Most, if not all, of these students have sought medical education abroad with the expectation that they will be able to return to the United States and develop careers as physicians. Many students desire to transfer with advanced standing to U.S. schools. For all students, the opportunity to complete their career development is dependent upon their gaining access to graduate medical education in the U.S.

PRESENT STATE OF POLICY DEVELOPMENT:

In 1969, the Association instituted the Coordinated Transfer Program (COTRANS) to facilitate U.S. citizens in foreign medical schools obtaining information regarding which schools might accept them as transfers at the clinical level and to assist their being admitted to take Part I of the NBME.

In 1972, the Executive Council recommended that the "Fifth Pathway" alternative, developed by the Council on Medical Education of the AMA, not be endorsed and that the medical schools should become more heavily involved in utilizing the COTRANS program to facilitate the transfer of qualified U.S. citizens studying medicine abroad into United States medical schools.

The FMG Task Force report, approved by the Executive Council in March 1974, recommends that the AAMC and interested medical schools sponsor a pilot project to identify and correct educational deficiencies in FMG's, particularly U.S. citizens, and to bring them to a level of professional competence comparable to domestic graduates. This report also recommends that a uniform qualifying examination be administered to all graduates of U.S. and foreign medical schools seeking graduate training in this country.

PROGRESS TOWARD ACCOMPLISHMENT:

Presently, 47 medical schools are listed in the COTRANS program as being interested in accepting U.S. citizens currently in foreign medical schools. There has been an increasing utilization of COTRANS by students in foreign schools: 270 in 1970, 437 in 1971, 676 in 1972, 957 in 1973. However, not all students whose credentials are verified by the COTRANS program and who pass Part I of the National Boards are accepted into United States medical schools as transfer students.

The AAMC is currently seeking foundation support to implement the pilot project mentioned above. As pressures from this large contingent of U.S. citizens mount, medical schools may be asked to develop special undergraduate and graduate programs to facilitate the career development of this group.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/
Division of Student Programs; Division of International Medical Education

AAMC COMMITTEE:

ISSUE: WHAT SHOULD BE THE MAGNITUDE OF OUR NATIONAL EFFORT IN BIOMEDICAL RESEARCH?

The total national health cost rose from approximately \$26 billion in 1960 to \$83 billion in 1972. During the same interval, Federal health expenditures rose ten-fold from \$3 billion to almost \$30 billion. National expenditures for biomedical research in 1972 were \$3.3 billion which contrasts with an expenditure of \$0.84 billion in 1960. Two-thirds of our national expenditures for biomedical research and development derive from Federal sources, 28% from industry and 8% from other private and public sources.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC policy on this matter is articulated in the document entitled, "A Policy for Biomedical Research," (*J. Med. Educ.*, Vol. 46: 689-743, No. 8, August 1971). It is recommended that the Nation adopt a policy supporting more, rather than less, biomedical research, in full recognition of the fact that no other course can offer hope for ultimate solutions to health problems. It was further recommended that the national policy for biomedical research assure support at levels sufficient to engage all qualified brainpower and that consideration be given to expansion at a rate determined by widening research opportunities.

The Committee on Biomedical Research and Research Training has recently reviewed this matter and has recommended that 5% of our national health expenditures be earmarked for the support of biomedical research. This is a very low rate of investment for the development of new knowledge and technology for our national health industry which is rooted in scientific and technologic innovation. Most technologically based industries devote more than 5% of their resources to research and development activities.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC was instrumental in establishing the Coalition for Health Funding, which represents over 40 organizations concerned that Federal health programs are adequately funded. AAMC officers have testified on research appropriations and have encouraged other organizations to support research funding.

In 1973, the Association successfully brought suit forcing the expenditure of Congressionally-appropriated research money which had been impounded by the Executive branch.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/
Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: HOW AND BY WHOM SHOULD NATIONAL RESEARCH PRIORITIES BE DETERMINED?

Traditionally, the budget of the NIH and the NIMH had been determined following a dialogue which involved the Executive and Legislative branches of the Federal government, the public and the various non-profit, voluntary health organizations. The budgets of the NIH and NIMH have been presented to the Congress and the public in such a manner that an interested person or group could evaluate the planned Federal expenditures in an area of concern without much difficulty and could then express his interest in changing the allocation of resources to the legislature. Recently, there has been discussion of presenting the budget of the NIH and the NIMH to the Congress as a single line item rather than the usual institute by institute fashion.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association of American Medical Colleges believes that the allocation of resources to our national biomedical research effort and the distribution of these resources should be the subject of a public debate involving both the various branches of the government and the public. Presentation of the budget of the NIH or the NIMH as a single line item would usurp the opportunity for individuals and organizations interested in various aspects of the Federal budget to have an opportunity to express their concerns before Congress.

The Association also supports the role of the national advisory councils, which provide both public and scientific input into determining which research programs within an institute deserve priority in funding.

The Executive Council on June 21, 1974 endorsed the recommendations of the Conference on Biomedical Research Manpower, sponsored by the AAMC Council of Academic Societies in October 1973. The conference recommended the establishment of a study group to suggest guidelines for the allocation of resources to basic and applied biomedical research.

PROGRESS TOWARD ACCOMPLISHMENT:

In testimony before Congress, letters to the Secretary of HEW, and discussion with Federal officials, the Association has strongly supported the role of Congress and the advisory councils in determining Federal research priorities. The AAMC has urged that appointments to study sections and advisory councils not be influenced by the political affiliation of the nominee.

The Association has recommended to HEW officials that the President's Biomedical Research Panel, established by the National Cancer Act Amendments of 1974, be requested to examine the substantive character of the nation's current biomedical research effort; the basis upon which a national program of biomedical research should be established, and the resources required to implement and maintain that policy. The Association also suggested the names of individuals for consideration as panel members.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: WHAT IS THE APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT IN THE SUPPORT OF TRAINING OF BIOMEDICAL RESEARCH SCIENTISTS?

The major health problem for the United States is the continued existence of incapacitating or fatal diseases for which we have neither adequate treatment nor mechanisms for cure. Research in the biomedical sciences offers the only rational approach to this problem. Excellence in research does not automatically follow the flow of funds into a field. It requires the recruitment, training, and cultivation of that relatively small number of individuals capable of working at the frontiers of scientific creativity. The predominant role of the Federal government in the support of the nation's biomedical research enterprise is well established; it, therefore, follows that the Federal government should also accept the responsibility for assurance of the quality and quantity of the nation's biomedical research manpower pool.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has been actively concerned with ensuring adequate support for the training of biomedical research scientists. Formal policy of the Association on this issue is articulated in the document, "A Policy for Biomedical Research," (*J. Med. Educ*, Vol. 46: 689-743, No. 8, August 1971). In this document, it was recommended that the administration and the Congress be urged to continue Federal programs providing fellowships and other stipends for advanced training in the health sciences and clinical specialties. More recently, the Committee on Biomedical Research has considered this matter and has recommended: That the Federal government has the responsibility to support training for research in the biomedical sciences and that the support of such training should be related to the anticipated needs, variety, quality and quantity of qualified biomedical scientists. To achieve this goal, the Committee recommends that a more formal mechanism be established to examine, on an on-going basis, both the supply and demand for biomedical scientific manpower by discipline category, with the recognition of the long-lag phase between entry into the training pipeline and the emergence of an independently competent investigator.

The Executive Council on June 21, 1974 endorsed the recommendations of the conference on Biomedical Research Manpower sponsored by the AAMC Council of Academic Societies in October 1973. The conference called for the establishment of a national commission to determine the appropriate role of the Federal government in support of biomedical research and research training.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has testified in support of training legislation, both in the House and Senate and successfully brought suit to force the expenditure of Congressionally-appropriated research training funds which had been impounded by the Executive Branch.

The Congress has recognized the need for a study to establish biomedical research manpower requirements and to assess and evaluate current Federal training programs. The National Research Act, enacted July 12, 1974 authorized the Secretary, HEW to request the National Academy of Sciences to conduct such a study.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: WHO IS RESPONSIBLE FOR ENSURING THAT THE RIGHTS OF THE SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH ARE PROTECTED?

There is increasing public concern regarding the protection of human subjects in biomedical research. The National Research Act enacted July 12, 1974 has established a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The DHEW is also in the process of modifying its guidelines for biomedical research involving human subjects and is in the process of adding new regulations pertaining to institutionalized subjects with limited ability to provide informed consent.

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC policy on this issue is predicated on the fact that biomedical research involving human subjects is an essential component of the process whereby new and innovative ideas are evaluated before being made available to the public as accepted modalities of health care. The Executive Council approved a policy statement in September 1972 asserting that academic medical centers have the responsibility for ensuring that all biomedical investigations conducted under their sponsorship involving human subjects are moral, ethical, and legal. The centers must have rigorous and effective procedures for reviewing prospectively all investigations involving human subjects based on the *DHEW Guidelines for the Protection of Human Subjects* as amended December 1, 1971. Those faculty members charged with this responsibility should be assisted by lay individuals with special concern for these matters. Ensuring respect for human rights and dignity is integral to the educational responsibility of the institutions and their faculties.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has actively supported legislation directed toward the establishment of national standards for the ethical aspects of biomedical research and has participated in the revision of the Department of Health, Education and Welfare Guidelines which pertain to the Protection of Human Subjects participating in biomedical research in situations in which there are limitations on the ability of the subject to give informed consent, i.e., the child, the institutionalized mentally disabled and the prisoner.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research will be in existence for two years, and then be replaced by a permanent National Advisory Council for the Protection of Subjects of Biomedical and Behavioral Research. The Association will recommend the names of individuals for consideration as commission members.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE: Committee on Biomedical Research and Research Training

ISSUE: WHAT SHOULD THE AAMC AND ITS MEMBER INSTITUTIONS DO TO REMEDY THE MALDISTRIBUTION OF PHYSICIANS AMONG SPECIALTIES?

There is a growing consensus that the pattern of specialization among physicians is inconsistent with the health care needs of the Nation. Although the precise forecasting of the numbers and types of specialists which will be needed in the future is inexact, presently, conventional wisdom concludes that considerably more generalists-specialists are needed and considerably fewer more narrow specialists are needed.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association adopted as its major emphasis during 1973 the improvement of education for primary care specialists. The Graduate Medical Education Committee has recommended that 50% of graduating medical students should become primary care specialists. This has also been endorsed by the Committee on Physician Distribution of the Coordinating Council on Medical Education. The Executive Council on September 20, 1974 approved the CCME Committee's report, which recommended that (1) medical schools should provide an appropriate environment, clinical resources, and curricula that will motivate students to select careers related to the teaching and practice of primary care; (2) institutions responsible for graduate education should establish residencies in family practice, internal medicine, and pediatrics which are oriented toward primary care and are equal in professional status with education programs in the medical and pediatric subspecialties, and (3) educational institutions should develop better methods for delivery of primary care.

The AAMC Executive Council approved a proposal for the renewal of health manpower legislation which would provide the incentive of additional capitation support to schools undertaking primary care education initiatives.

PROGRESS TOWARD ACCOMPLISHMENT:

In the Fall of 1974, the Association will sponsor an Institute on Primary Care. Through its position on institutional responsibility for graduate medical education, the Association has urged the academic medical centers to develop decision-making processes regarding the numbers and types of residency and fellowship programs they sponsor. The Association is cooperating with specialty groups seeking to determine the numbers of specialists being trained and projecting these numbers against predictions of future needs. Current negotiations are underway with the AMA to develop a feedback system to the schools so that they will be informed regarding the selections their students make for specialty training and ultimate career development.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies; Department of Health Services; Department of Academic Affairs

AAMC COMMITTEE: CCME; Graduate Medical Education Committee; Task Force on Primary Care

ISSUE: WHAT SHOULD THE AAMC AND ITS MEMBER INSTITUTIONS DO TO REMEDY THE MALDISTRIBUTION OF PHYSICIANS AMONG GEOGRAPHIC AREAS?

Geographic maldistribution of physicians is a major public concern. There are complex interrelated reasons why physicians choose one particular societal and geographic setting over another in which to establish themselves. Generally, physicians are attracted to affluent communities which provide recreational and cultural opportunities compatible with their educational background and experience. Current short-term solutions for providing physician services to both metropolitan and rural shortage areas include loan-forgiveness, service-commitment scholarships, student recruitment from underserved areas, and the National Health Service Corps. There is an increasing interest in the Congress in making Federal support for medical education contingent on mandatory service by graduates in underserved areas.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association has supported the short-term solutions for assuring the availability of health personnel for underserved communities, and has recommended that these programs be strengthened and expanded. The Association views the proposed mandatory service as an inadequate solution to the maldistribution of physicians; more appropriate solutions are the programs designed to provide students with prior exposure through community outreach programs to underserved areas, with the expectation that such exposure will affect their practice location. The Association endorses the National Health Service Scholarships and the Corps as a volunteer mechanism to provide health professional personnel and the needed infrastructure to provide care in underserved areas.

PROGRESS TOWARD ACCOMPLISHMENT:

Promoting the provision of student experiences in areas of chronic physician shortage (rural and urban inner city) has not been specifically planned, and cannot effectively be accomplished without special financial resources. Long range plans for sustaining regionalized programs are essential. The Association has supported legislation which would provide resources to enable academic medical centers to provide education and care in shortage areas, as the most promising and equitable long-term solutions to the geographic maldistribution problem. It has also supported the legislation to establish the National Health Service Corps and the appropriations to support the programs.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

ISSUE: SHOULD ACADEMIC MEDICAL CENTERS ASSUME RESPONSIBILITY FOR DEVELOPING NEW MODES OF PROVIDING HEALTH CARE?

In the midst of the debate over national health insurance and the various approaches to improving the financing and delivery of health services, the HMO and the restructured outpatient department have emerged as possible alternative approaches toward improving health care. The problem of inefficiency of operation and inadequacy of services in the traditional OPD are well known. The university-operated OPD in particular, suffers from inadequate funding, inefficient organization, rising costs and increased workloads

PRESENT STATE OF POLICY DEVELOPMENT:

This issue must be addressed by each constituent institution, taking into account local needs, resources and interests. Because of their unique resources, academic medical centers bring to the development of health care services the full spectrum of medical, social and behavioral sciences. The experiments of those institutions in HMO development and operation, as well as OPD restructuring could well serve as models for other academic medical centers that anticipate adopting these approaches to health care delivery.

Past AAMC testimony on health maintenance organizations has supported the request of funds for the development of academic medical center related HMOs.

PROGRESS TOWARD ACCOMPLISHMENT:

In 1972 the Department of Health Services contracted with the HMO office of HEW to assist in the development of prototype HMOs affiliated with academic medical centers. The five institutions selected to participate have received consultative support and technical assistance to develop their HMO models. Although the project will terminated in June, 1974, the participating institutions may apply for direct Federal assistance for further planning, development and operational support.

The Department of Health Services is submitting a proposal for support of a project to strengthen and upgrade university outpatient departments. The project's major emphasis will be on restructuring OPD activities into a strong academic base for primary care and on facilitating their integration with the overall institutional program. If funds are obtained, the Departmental staff will provide technical assistance and consultation to AAMC institutional members that are interested in OPD reorganization.

The prototype HMO project has made it possible for five selected academic medical centers to receive support and assistance in addressing the various critical issues attendant to the development of an HMO. After termination of the project, the Association will prepare a final report and a list of consultants to be made available to all interested constituent institutions.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee

ISSUE: WHAT IS THE ROLE OF THE MEDICAL SCHOOLS AND TEACHING HOSPITALS IN TEACHING HEALTH PROFESSIONALS TO WORK AS A TEAM, BETTER RELATING RESPONSIBILITY TO TRAINING?

The immediate demand for primary medical services coupled with the current geographic and specialty maldistribution of physician manpower requires alternate approaches to the health manpower shortage. Training programs for new health care practitioners such as physicians' assistants and nurse practitioners have developed partially in response to this need. In order to function effectively as a team, the new health professionals and physicians should be trained together in clinical settings which focus on their collective roles and responsibilities as member of a provider unit. Such joint interdisciplinary training has the potential for increasing the supply and effectiveness of primary care personnel for both urban and rural populations.

PRESENT STATE OF POLICY DEVELOPMENT:

Although this is an institutional responsibility dependent upon local needs and resources, the AAMC strongly encourages constituent efforts in seeking programmatic support for these activities.

It is felt that the academic medical centers might take an active role in developing common core curricula for medical students and new health practitioners which reflect a team approach to the delivery of primary health services. However, there is need for experimentation in the clinical environment to evaluate the validity of the team concept, of various approaches to organization and structure, and of the most effective means to integrate this concept into clinical education.

The Association's Health Manpower Legislation proposal, as approved by the Executive Council, supports interdisciplinary training through capitation incentives.

PROGRESS TOWARD ACCOMPLISHMENT:

An AAMC survey in 1973 identified 69 academic medical centers currently involved in educational programs for new health practitioners. One third of these programs have students attending didactic courses with medical students and two-thirds training medical students and health practitioners students together in clinical settings.

On May 1, 1974, the Department of Health Services signed a contract with BHRD to develop pilot physician training programs in HMOs, one component of which will explore the integration of training programs for physicians and new health practitioners.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee

ISSUE: HOW SHOULD HOSPITAL COSTS BE CONTROLLED?

Final regulations regarding Section 223 of P. L. 92-603 limit Medicare reimbursement for per diem routine service cost of groups of "similar hospitals." For the purpose of limitation all short term hospitals in the United States are subdivided into 70 groups based upon: (1) Number of adult and pediatric beds (7 categories); (2) State per capita income grouping (5 categories); and (3) Metropolitan area designation (2 categories).

The present hospital classification scheme employed in implementing the regulations, however, does not take into account case mix or the nature of facilities provided. As such, hospitals producing different types of products, are grouped together for cost comparison purposes. Teaching hospitals having a complex case mix and providing a wide variety of tertiary services and facilities are compared with hospitals having less complex case mixes and providing a more limited array of services.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association's position is that by not accounting for case mix and the nature of facilities and services offered, the Social Security Administration has developed a classification scheme that will deny reimbursement for costs that are, in every way, reasonable. A staff study, "Classifying Short-term hospitals for Routine Service Cost Limitation Under Section 223 of: P. L. 92-603: A Critical Analysis," demonstrates the SSA hospital grouping methodology was no more efficient than if hospitals had been assigned to groups through an arbitrary or random procedure. The staff paper was distributed to the Assembly on May 28, 1974, and the Executive Council approved the AAMC position on June 21, 1974.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association's position has been presented to the Social Security Administration which is now engaging in a process seeking to modify the presently employed hospital classification methodology. Staff of the Association will participate in this process through involvement on a technical advisory committee established by SSA.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Teaching Hospitals

AAMC COMMITTEE: Ad Hoc Committee on Economic Controls