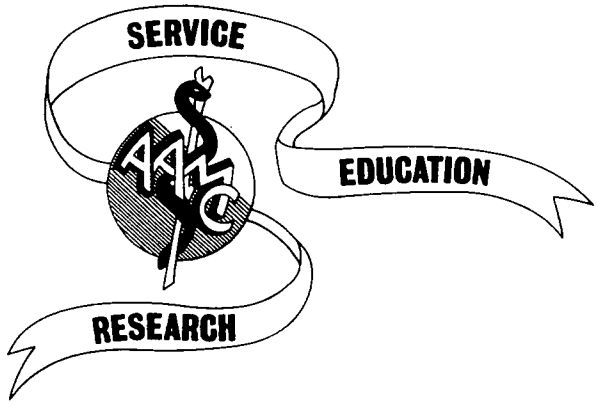

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

Thursday, March 15, 1973

9:30 AM - 4:00 PM

Room 827, 8th Floor
1 Dupont Circle, N.W.
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

December 14, 1972

AAMC Headquarters
Washington, D.C.

	Board Members	Staff
PRESENT:	Robert G. Petersdorf, Chairman (Presiding)	Michael F. Ball
	Robert M. Blizzard	L. Thompson Bowles
	David R. Challoner	Connie Choate
	**Sam L. Clark, Jr.	*John A.D. Cooper
	Ludwig Eichna	Mary H. Littlemeyer
	Ronald W. Estabrook	Joseph S. Murtaugh
	Charles F. Gregory	August G. Swanson
	Rolla B. Hill, Jr.	
	**Ernst Knobil	

	Board Members	Guest
ABSENT:	Robert E. Forster, II	*Charles C. Sprague
	William B. Weil, Jr.	

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting held September 14, 1972 were adopted as circulated.

II. Chairman's Report

Dr. Petersdorf reported on the AAMC Officers' Retreat held November 30-December 2. The purpose of the retreat was to review the activities of the Association and to set new goals for the coming year. Summary notes and the agenda outline of that meeting are attached (Exhibit A).

*For part of meeting
**Ex Officio

III. Discussion Items

The morning was principally devoted to a discussion of the special role the CAS can assume in furthering the programs of the Association. On pages 21 and 22 in the agenda, 17 programs of importance to all three AAMC Councils were listed. In opening the discussion, Dr. Petersdorf commented that in his opinion the CAS should define a few, say two or three, programs and concentrate its efforts on these. First to be considered was a topic, according to Dr. Estabrook discussed at the Officer's Retreat--the need for greater participation by the CAS in accreditation visits. The Administrative Board agreed that this was an appropriate area for major CAS focus in the upcoming year.

Reviewing antecedent interests in this area, Dr. Clark cited the resolution offered by Dr. Tosteson and adopted by the full Council at the fall meeting in Miami:

> "Dr. D.C. Tosteson urged that the CAS Administrative Board consider the organization of a CAS committee on accreditation whose primary function would be to develop a mechanism for involvement of the CAS in institutional accreditation."

Dr. Knobil related his dismay at a "Medical School" to which he had recently paid an accreditation visit. Among other notable departures from the post-Flexnerian medical school were the absence of basic sciences faculty and basic science departments. Although several basic science groups have current activities related to establishment of accreditation criteria, at this time no one can claim with any authority that a given amount of physiology, etc., should be taught. The unfortunate facts are

that the Congressional pressures for the primary care physician continue to spiral, while the medical educators who accredit schools cannot claim that the product of "a medical school" which has no basic science departments will be inferior to the "traditional" medical school. Yet, as Dr. Clark pointed out, the more explicit the team's action, the closer the schools will come to a national curriculum. The credibility of the accreditation team, as currently constituted, was questioned.

In conclusion, a number of positive suggestions were offered. First and foremost, was that faculty participation in accrediting medical schools should be promoted. To be in a position to offer sound advice, Dr. Clark pointed out, one needs to become better acquainted with the accreditation process as it is now carried out. There is a definite need for improved guidelines and the Chairman groups should be encouraged to pursue the formulation of accreditation criteria. The basic sciences also need help in developing a way to instill the basic sciences as an integral and vital component of both clinical science and continuing education. Dr. Knobil felt strongly that the membership of the accreditation teams, in view of the life and death decisions for which they are responsible, should be increased in size.

Finally, the Board authorized Dr. Petersdorf to name an ad hoc committee representing basic and clinical science professorial groups and CAS Administrative Board to pursue the matter of greater faculty participation in the accreditation of undergraduate medical education.

IV. Information Items

Spring meetings the CAS has scheduled are to be held at the Mayflower Hotel in Washington, D.C. (previously scheduled for New Orleans). They are:

March 28 - Business Meeting

March 29 - NIH Workshop

March 30-31 - Curriculum Workshop

The Board supported the same format for future Business Meetings that was used in Miami. The agenda prepared and the conduct of the session permitted informed participation by the membership. It was suggested that the March meeting convene at 10:00 a.m. to enable East Coast arrivals that morning.

The need for improved communications with CAS constituents was emphasized. Some members have received the erroneous information that their tax-exempt 501 (c) 3 status would be jeopardized by supporting the CAS dues increase. Dr. Blizzard said this was the case with the Endocrine Society. Also, Dr. Blizzard indicated the Pediatric Department Chairmen group is thinking of withdrawing from CAS membership, a phenomenon that was attributed to too little on-line information about the CAS. The reason for this was not at all clear, since during the past year both AAMC President Dr. Cooper and Dr. Swanson had met with the Pediatric Department Chairmen group. Dr. Petersdorf said once again how useful Dr. Cooper's Weekly Report is and mentioned that quantities of 50 are now available for only the cost of the postage.

Nevertheless, it was felt that CAS representatives had too few facts about CAS to promote it to the organizations represented. One suggestion from CAS representative Doug Eastwood was that a "CAS kit" be prepared. He wrote his suggestion to Dr. Estabrook as follows:

> "I think CAS representatives need a kit of materials to use in reporting to their parent organization with information in brief about:
>
> 1. Organization of AAMC - representation in the Assembly - dues of each of the Councils and individual membership.
>
> 2. Basis for raising dues.
>
> 3. Important actions and aspirations of CAS for 1973 and on. Could Dr. Swanson be of help in this?
>
> It would make a report by each representative more likely to produce the desired results, especially with the dues increase."

Staff will develop an informational kit which CAS Representatives can use to explain activities of the AAMC-CAS to the societies they represent at their annual meetings.

The Administrative Board agreed to have an all-day business meeting on Sunday, November 4, 1973, with the CAS general session on Monday afternoon, November 5. If the Council of Deans wish to join the CAS plenary session on November 5, they will be welcome to do so. Pros and cons of a joint meeting were raised. Participation by the COD increases attendance, but the CAS could benefit by improved visibility via a meeting sponsored solely by CAS. The AAMC fall annual meeting as it is now scheduled is sketched below:

Sunday Nov. 4	Monday Nov. 5	Tuesday Nov. 6	Wednesday Nov. 7	Thursday Nov. 8
CAS Business Meeting	AAMC Plenary Session	AAMC Plenary Session	Councils*	Misc.
10:00 a.m. 5:00 p.m.	CAS Plenary Session*	Assembly	Misc.	

The CAS Administrative Board favored joint meetings with representatives from the federal government as a part of the regularly scheduled Board meetings. If the two top HEW posts recently vacated have been filled far enough ahead of the March meeting, an attempt will be made to attract one of these individuals to meet with the Board.

Dr. Ball briefed the Board on the new AAMC Committee on Biomedical Research and Research Training which is under the Chairmanship of Dr. Eugene Braunwald. A list of the full membership of the committee is attached (Exhibit B). Among the tasks assigned to this committee is to assertain the contribution of biomedical research to undergraduate medical education. The General Research Support concept is being questioned. Determination of this as a source of support in undergraduate medical education will need to be established. When called upon by the Braunwald Committee, the CAS will cooperate in gathering data from its membership as to the value of the General Research Support.

Panels of experts will be drawn from the CAS member societies for guidance in developing multimedia teaching systems and inter-institutional

*Other Councils may meet at this time.

educational networking. Dr. Knobil indicated that the American Physiological Society has worked with the National Medical Audiovisual Center and will be a valuable resource. It was noted that all societies, not just the professorial societies, would be called upon. The activities of the large colleges, using multimedia effectively in continuing education was also mentioned. It is expected that Dr. William Cooper, who will head the new AAMC effort, will have a preliminary report for the Council's March meeting.

The CAS will participate with the AAMC's other Councils in the activity to promote the development of new models for providing primary care.

An item agreed to be a high priority for CAS attention was promoting the development and retention of medical school faculty. As medical school support is decreasing, the pressure on faculty to produce more is increasing.

Dr. Petersdorf was authorized to appoint an ad hoc committee to study this matter with the expectation that it can formulate a position report.

The CAS expects to be involved in improving the function and educational effectiveness of ambulatory care in academic settings.

The AAMC Committee under the Chairmanship of Dr. Robert Weiss has already been activated to promote the development of mechanisms to satisfy requirements for assuring the quality of health care. Dr. Challoner serves on this committee and will keep the CAS Administrative Board informed on ways in which CAS constituent societies could most effectively contribute to this study.

For the March business meeting, Dr. Petersdorf asked that the

following CAS Administrative Board members present reports for the committees on which they serve:

Dr. Estabrook - Biomedical Research
Dr. Clark - Graduate Medical Education
Dr. Challoner - Quality of Care

The following Membership Applications received were assigned for review:

Societies	Reviewers
American Academy of Orthopaedic Surgeons	Drs. Gregory and Petersdorf
American Urological Association	Drs. Blizzard and Knobil
American Society of Therapeutic Radiologists	Drs. Challoner and Eichna
American College of Chest Physicians	Drs. Hill and Weil

The formal meeting of the CAS Administrative Board was adjourned at noon when it joined with members of the COD and COTH Administrative Boards to hear Tom Tierney, Director of the Social Security Administration, Bureau of Health Insurance and his associate Bob Hoyer to discuss professional fee payments in the teaching setting under Medicare. Beginning July 1, 1973 institutions will be paid cost unless supervising physicians meet private patient relationship requirements or since 1965 have billed all patients and collected from a majority of them. Mr. Tierney stated there would be some changes in Intermediary Letter No. 372, and again stated that Medicare was not designed to finance medical education. He indicated a willingness to work with AAMC, and suggested an ad hoc committee be formed to assist the SSA staff in reviewing guidelines on this issue. A committee has been appointed with Bob Derzon, Director, University of California Hospitals and

and Clinics, San Francisco as chairman. Other members of the committee are: Robert Van Citters, M.D., Dean, University of Washington, School of Medicine; L. Edgar Lee, Jr., M.D., Assistant Dean for Administration, Case Western Reserve; Arnold S. Relman, M.D., Chairman, Department of Medicine, University of Pennsylvania; G. Thomas Shires, M.D., Chairman, Department of Surgery, University of Texas Southwestern at Dallas; John M. Dennis, M.D., Professor of Radiology, University of Maryland; and Charles B. Womer, Director, Yale-New Haven Hospital.

V. Next Meeting

The next meeting of the CAS Administrative Board is March 15, 1973, 9:00 a.m. - 3:00 p.m., at the AAMC Headquarters.

MHL:smc
ATT: 2
12/20/72

REPORT OF THE AAMC OFFICERS' RETREAT

December, 1972

The Chairman and Chairman-Elect of the Association along with the Chairman and Chairman-Elect of each Council, the OSR Chairman and key AAMC staff met from November 30 - December 2 to review the activities of the Association and to set new goals for the coming year.

Foremost among the new priorities established for the Association was a Primary Care initiative. The stated objectives of this program are: 1) development of models for the delivery of primary care by teams of health professionals; 2) implementation of models by medical schools to evaluate effectiveness and train health professionals as a team; and 3) promotion of new models for delivery of primary care in the community. The Retreat participants instructed the AAMC staff to prepare eventually a White Paper on Primary Care, organize an Institute on Primary Care, and seek Federal support for innovative models of primary care delivery.

Other new programs given top priority by the Retreat participants included the launching of an active Coordinating Council on Medical Education, a feasibility study of a medical school applicant matching program, and the involvement of the academic health centers in the determination of quality of care. Specifically recommended was the development of prototype quality assurance programs, efforts to advance quality assessment methodology, and the eventual creation of academic health center PSROs.

The Retreat participants reviewed with considerable interest and commented on a number of recently initiated and ongoing AAMC programs. Of particular interest were the Data Development and Analysis Program and the Management Improvement and Systems Development Program. The Officers concurred in the plan to evaluate thoroughly what data should be collected and disseminated. Also recognized was the success of Phase I of the Management Advancement seminars and the potential value of the AAMC's coordinating role in developing management systems which would be made available to the health centers. It was suggested that the Association better inform the constituency of the advantages of these new programs for the institutions.

The Minority Affairs activities of the Association came under the scrutiny of the Retreat. A statement issued by a small group of minority students at the AAMC Annual Meeting calling for a complete reorganization

of these activities was examined and dismissed after the accomplishments of the Association's Office of Minority Affairs were noted. The provision of better preparatory education, beginning at the grammar school level, was seen as the only complete solution to the schools problem of producing a representative number of minority group physicians. In lieu of this solution, special recruitment and retention programs remain necessary.

High priority was also given to the AAMC's expanded activities on behalf of biomedical research and research training. The need to support young investigators was emphasized, along with the vital role of training grants and general research support grants.

Other programs receiving detailed consideration and emphasis included women in medicine, graduate medical education, and expanded activities in the international arena.

Legislative priorities for the coming year were discussed, and AAMC policies needing review or supplementation were identified. Of particular concern was the Association's lack of an aggressive stance on national health insurance. Other concerns centered around funding priorities and the feasibility of a public stance regarding the creation of new medical schools.

In other deliberations, the Retreat participants discussed the implications of HR 1 and what the AAMC might do on the national level to alleviate the potentially disastrous effects on the medical centers. Relationships with other organizations in the health field were reviewed, particularly in terms of the time commitment required to relate to every group desiring a continuing liaison. The Association staff was instructed to present a position paper to the Executive Committee in March detailing the relationship with associations representing the various health professions schools and with the Vice Presidents for Health Affairs.

As a final action, the Retreat approved a proposal presented by Dr. Sprague suggesting that the 1973 Annual Meeting examine the changing role of the physician in the U. S. and abroad. Several international speakers would discuss the experiences of their countries, which would then be related to the American physician. A suggested theme for the meeting would be, "Preparation and Role of the Physician: Comparative Approaches."

Further consideration of Annual Meeting format and speakers was referred to the Executive Committee.

RETREAT AGENDA

COMMITTEE ON BIOMEDICAL RESEARCH AND RESEARCH TRAINING

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December 13, 1972

GUIDELINES FOR ACADEMIC MEDICAL CENTERS PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

CONTENTS

FOREWORD

The Assembly of the AAMC approved a statement in November of 1971 urging that the academic medical centers assume institutional responsibility for graduate medical education. These guidelines have been developed to assist faculties seeking to develop a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers.

In developing this document, the Graduate Medical Education Committee and the staff drew heavily upon earlier committee reports. These are mentioned in the Historical Summary and should be referred to by faculties and their planning committees. The Historical Summary also sets forth the rapid and accelerating change in graduate medical education in the United States.

Because the rate of change in graduate medical education has been paralleled by an increasing complexity of academic medical centers, it has been necessary to keep these guidelines broad. Major conceptual ideas for which policies and administrative detail must be developed are set forth. It was not intended that a single best solution be promulgated.

The value of these guidelines will be enhanced if the specific problems which are met and resolved (or not resolved) by the institutions as they attempt to meet the Assembly's challenge are communicated on a national level. From the aggregate experience plans for specific studies in national policy development can be derived.

I. INTRODUCTION

Graduate medical education is the process that differentiates the multipotential holder of the M.D. degree into a competent, professional physician who has the requisite knowledge, skills and judgement to begin a lifelong career of service and learning in a delimited area of medical practice.

This document sets forth guidelines for the development of overall institutional responsibility for graduate medical education. It is particularly directed towards academic medical centers with medical schools conducting undergraduate programs leading to the M.D. degree, but it has broad applicability to all institutions conducting programs for the graduate education and training of medical specialists.

II. HISTORICAL SUMMARY

Attaining the M.D. degree now signifies that the recipient is prepared for further education rather than for an independent professional career. The degree is a benchmark of transition from the first phase of formal medical education to the second. In the first phase the goal is to educate and train students in the basic and clinical sciences to the point that they are capable of obtaining clinical, social, and cultural data from a variety of patients; are able to assimilate and record these data in a logical and coherent fashion and

correlate this information, to a limited degree, with the existing body of biomedical, scientific knowledge in arriving at diagnostic and therapeutic decisions. As the body of knowledge has grown and the skills for collecting data and providing therapy have become more and more complex, the undergraduate phase of medical education and training has been complemented by a formalized graduate phase.

This phase, largely based upon direct responsibility for patient care, has developed as an apprenticeship system, supervised and controlled by each specialty discipline. National standards for accreditation of graduate programs and for certification of individuals by examination have been evolved by each specialty. Directors for each specialty graduate program are principally guided by these national standards.

In general the system has been successful and has produced highly trained and skilled specialists. However, the reliance on national policies, established solely by specialists in each discipline, for accreditation and certification has not been optimally responsive to societal needs and has produced a relatively inflexible graduate medical educational system which tends to neglect the variations in residents, institutional characteristics, institutional missions and national and regional health service needs.

The nation's medical schools are now providing staff and facilities for the graduate education of 80% of their M.D.

recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a larger degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train.

Granting the M.D. degree has been the responsibility of academic institutions for the past fifty years. The assumption of this responsibility terminated the era when medical education was controlled largely by the practicing profession. As a result, new standards derived from the broad perspective of the universities promoted an adherence to excellence in scientific and clinical education and created institutions capable of scientific investigation and the application of new biomedical knowledge to medicine.

Medical schools, as they became components of universities, established their medical educational programs by achieveing a consensus of the entire faculty of the school. This involved both basic scientists and clinicians. Criteria for student selection and standards for promotion and graduation also were considered to be a responsibility of the entire faculty. While constrained to a degree by state licensure laws, accreditation standards, and the "conventional wisdom" of the medical establishment, schools could develop special curricula and instructional techniques peculiarly suited to their students, their resources, and the needs of their communities or regions. Until the mid-50's, few schools made sig-

nificant experiments in modifying the conventional (i.e., 2 basic science years, 2 clinical years) mode of the traditional four-year undergraduate education for the M.D. degree. During the past fifteen years, and particularly during the past five, new approaches to undergraduate education have been common. The forces promoting curricular experimentation are complex, and they vary from one institution to another. The opportunity to depart from tradition is in large measure afforded by the willingness of the accrediting agency (the Liaison Committee on Medical Education), state examining boards and other public agencies to trust that the "corporate wisdom" of the entire faculty of a medical school will assure maintenance of basic and fundamental academic standards. This trust has been enhanced by the emergence of large full-time faculties in both the clinical and basic science departments. These faculties are considered to be of such high quality that they can be permitted a large degree of institutional self-determination for undergraduate medical education.

During the period when undergraduate education was traditional and essentially standardized, and most M.D. recipients entered practice after one year of internship, the purpose of graduate medical education was to produce a few qualified specialists in those clinical areas which required detailed knowledge and skills not ordinarily provided in the formal medical education program. It is not surprising that the first four boards established during the period from 1916

to 1932 were in Ophthalmology, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology. Individuals in these disciplines, concerned with assuring high standards of education and training for those who called themselves specialists, promoted the establishment of Boards to lay down national standards for program length and content and national examinations to assure the competence of those certified as specialists.

Reliance upon rather rigid standards for program characteristics and individual certification was necessitated by the diversity of settings for graduate medical education. Hospitals, both those affiliated with and not affiliated with medical schools, were the institutions for graduate medical education; and in either setting, the program for each specialty discipline was considered the sole responsibility of the specialists involved in that discipline. A broad institutional responsibility for graduate education, similar to that taken by the entire faculty for undergraduate medical education, did not evolve, even as the number of specialty Boards increased and as the setting for graduate medical education moved more and more into the academic environment of the medical schools.

While initially graduate education was largely conducted by full-time practitioner-specialists in the context of their own practice, the development of full-time, clinician-academicians in medical schools gradually moved the major responsibility for graduate medical education into the province

of academic medicine. Students promoted this transition by preferentially choosing programs established in academic settings over those lacking academic affiliations. During the past decade, Board members have been increasingly drawn from physicians in the academic environment.

In 1966 the AMA-sponsored Citizens' Commission on Graduate Medical Education, recognizing the significant engagement of academic medical centers with graduate medical education, recommended that the universities assume full responsibility for all of graduate medical education in the nation.[1] In 1968 the Council of Academic Societies of the AAMC published a report of a major conference on "The Role of the University in Graduate Medical Education." This report pointed out that although the setting for graduate medical education had shifted into the academic medical centers, there was insufficient recognition that these graduate programs were now a major responsibility of these institutions.[2] In 1971 the Assembly of the AAMC approved a statement urging the constituent members of the Association to assume responsibility for graduate medical education in a manner analogous to their assumption of responsibility for undergraduate medical education.[3,4]

The foregoing has related the movement of graduate medical education into the academic environment largely to the development of full-time clinical faculties and to student preference for the academic setting. Several other factors have been operant in this evolution.

The explosion in biomedical knowledge and technology largely is a product of the university-based medical school, and the most comprehensive exposure to this new information can be gained at the university centers. University centers have also commanded more resources for procuring advanced equipment and specialized personnel. While such expenditures have generally been for research purposes, the opportunity to learn the latest methodologies for patient care has been provided to graduate medical students in these settings.

Training programs supported by federal funds have largely gone to university-based medical centers. Thus, direct support for individuals seeking graduate education has been more available in programs directed by full-time, academic clinicians.

The ascendancy of graduate programs in the academic institutions has been significantly related to external forces, particularly those promoting research and increased specialism in medicine. The institutions, either individually or in the aggregate, have only recently realized that they must become concerned with the impact of their large graduate medical education commitments, on their resources and upon the characteristics and quality of medical practice in their communities and the nation.

During the past several years, significant changes have begun to develop in the national approach to accreditation of graduate programs and the certification of specialists.

These changes can provide opportunities for the faculties of graduate medical educational institutions to move toward a broader responsibility.

In the accreditation arena, the formation of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has established for the first time an opportunity for five major national organizations to participate in remodeling the accreditation of both undergraduate and graduate medical education. The parent organizations are: the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialty Societies. These provide for broad input into both the Coordinating Council and the Liaison Committee on both undergraduate and graduate medical education. It is likely that proposals for innovative improvements in educational programs will receive interested and sympathetic attention by these newly-formed bodies.

During the past decade, the specialty Boards have been seeking to improve their certification procedures for individuals. Increasingly they have turned to the National Board of Medical Examiners for advice and assistance. The National Board, recognizing that rapid changes are occurring in both undergraduate and graduate medical education, is in the process of reorganizing itself so that it can provide more effec-

tive service for certifying that recipients of the M.D. degree are prepared for entering graduate education and also assisting the Boards in developing assessment systems of high quality and validity.

In the discussion and debates which have led to the establishment of a new accrediting system and the reorganization of the National Board of Medical Examiners, it has been repeatedly emphasized by many who participated that the institutions of higher education which conduct programs for the education of physicians must assume greater responsibility for the quality of all programs conducted under their aegis. Further, there is general recognition that in a complex, pluralistic society, national agencies cannot effectively oversee either accreditation or certification without delegating responsibility to institutions which are dedicated to maintaining and improving quality.

At this point in time, the reorganization which has been accomplished on the national scene provides both an opportunity and a challenge to the academic medical centers to assume greater responsibility for and greater authority over graduate medical education.

III. GUIDELINES

A. DEFINITIONS

1. Graduate medical education is that period in the formal education and training of a physician which usually fol-

lows the granting of the M.D. degree and culminates in qualifying for certification in a specific clinical discipline. Certification is obtained by the satisfactory completion of a program of education and training, and passing an examination or examinations conceived and administered by a national body (Board) representing the discipline.

2. Graduate medical students are individuals, usually with an M.D. degree, who are enrolled in a graduate medical institution and are pursuing education and training in a program leading to certification in a clinical discipline. The traditional titles "intern", "resident", "clinical fellow" or "house officer" recognize the hospital-physician role of these individuals. Although such titles do not convey their semi-student status or their role in health care delivery outside the conventional hospital setting, the titles "resident" or "clinical fellow" are widely understood and are preferable to "student" or "trainee".

3. A graduate medical education program is a complete educational and training experience which prepares residents to assume independent responsibility for patient care in a specific clinical discipline.

4. The graduate medical education faculty in an institution ordinarily should include all the full-time and part-time faculty normally responsible for undergraduate medical education. The need to incorporate learning opportunities in the basic sciences into graduate programs will provide a

special challenge to the basic science faculty and their clinical colleagues. Institutions utilizing part-time clinician-teachers are encouraged to provide these individuals with appropriate input into program planning and appropriate recognition.

5. Academic medical centers with institutional responsibility for graduate medical education are institutions or institutional consortia which provide the spectrum of scientific and clinical faculty, the facilities, and the administrative capability necessary to plan, conduct and evaluate graduate education and training based upon policies and goals derived on an institution-wide basis.

B. THE INSTITUTIONAL SETTING

1. Introduction

Graduate medical education requires a special institutional setting. Academic medical centers planning to assume responsibility for graduate medical education must recognize the need for an institutional system capable of delivering health-care services, ranging from primary to tertiary, in a variety of settings.

In developing the health services appropriate for graduate programs, the centers will need to encourage the participation of individuals, institutions and agencies having primarily a service commitment, but willing to make a commitment to the academic mission. The new institutional form

derived from this amalgamation will have both special characteristics and special problems which may require changes in the conventional management and governing policies of either the academic or the health service institution. The academic programs and the service programs must be blended. The faculty must be composed of individuals with a variety of academic and professional capabilities; and as a faculty, must be capable of recognizing the contribution of all its segments to the common goals of education, service, and research.

Financing, although derived from multiple sources, must be apportioned to assure that the various missions of the institution remain in dynamic and effective balance.

2. Governance

a. Role of the Governing Board. The academic medical center which broadens its responsibilities to include graduate medical education must be cognizant of the need for a governing board made up of individuals who can understand its special problems and make policy decisions which range from those related to academic governance to those required in the institutional delivery of health care services. Where the academic center is a consortium of institutions with their own governing boards, a governance mechanism representing all institutions should be established to implement policy decisions related to the overall educational mission of the center and to articulate these policies with the service missions of the several constituent institutions.

The provision of health services to the community is essential for accomplishing the graduate medical education mission, and the board must be sensitive to the needs of the community for health services. There should be provisions made for input to the board from recipients of these services.

b. Role of the Faculty. Faculty should be responsible for policy development and program review of all facets of graduate medical education. Faculty from both basic and clinical academic departments should expect to contribute to the teaching programs of the various disciplines. In most institutions, mechanisms for ensuring that the faculty exercises this responsibility have been well developed for the undergraduate program leading to the M.D. degree. Because of the greater complexity of graduate education, it is particularly important that broad participation of members of the faculty, ranging from basic scientists to practicing clinicians, be engaged in setting standards for student selection, reviewing and approving curriculum plans, assessing the validity of resident evaluation procedures, and ratifying the graduation of residents from various graduate medical programs. This will necessitate establishing a multidisciplinary review system for each graduate program. An overall faculty committee for broad policy development and the adjudication of disagreements will surely be needed.

c. Role of the Residents and Fellows. Because residents and fellows are expected to educate and train those junior to

them and are also expected to share in the supervision of patient care provided by those with lesser experience, they should be provided appropriate involvement in the affairs of the institution. This involvement should be particularly directed toward enhancing their teaching and supervisory skills.

3. Administrative Arrangements

Administrative systems will vary depending upon the size and complexity of the academic medical center. The importance of providing for the following relationships is emphasized:

a. The ultimate responsibility and authority for the educational programs of the academic center should be lodged with an individual who has direct access to, and is also responsible to, the governing board. When the graduate medical institution is a consortium of institutions, the relationship of this administrative officer to each institutional member should be explicitly stated.

b. The undergraduate and graduate medical education programs should be administratively linked.

c. Because of the differential nature of graduate medical education, the specific programs leading to different disciplinary careers should be planned and implemented by faculty members specifically responsible for each program. However, the autonomous discretion of these program directors should be limited. The individual with overall responsibility for the center's educational programs should have administrative authority over each program director and should assure

that the selection of students, appointment of faculty, development of curricula, assessment of residents, evaluation of the educational process and outcomes and the commitment of resources for all programs are commensurate with the polcies for graduate medical education established by the entire faculty.

d. Because administering a health services delivery system is a complex task, it is likely that an individual with particular skills will be delegated this task. It is extremely important that this individual and his staff understand the interdependence of the service and educational programs of the center and that he be a member of the team of individuals responsible for the educational mission.

C. RESIDENT SELECTION, EVALUATION OF PROGRESS AND GRADUATION

1. Selection

Residents selected should ordinarily have achieved the M.D. degree or its equivalent. This is not to be construed to interdict programs which coordinate their curricula with the undergraduate medical school curricula of students who have made early career decisions for a specific discipline. Specific criteria for selection for each program should be developed and approved by the general faculty or a representative body of the faculty.

2. Evaluation of Progress

a. General. Procedures for evaluation and reporting the progress of residents in each program should be developed.

These procedures should include an assessment of knowledge, skills, performance and judgement in the particular discipline pursued and an overall assessment of attitudinal development. No specific examination or rating system is recommended but evaluation should be carried out by faculty members both within and without the resident's discipline. There should be clear evidence that progress is periodically evaluated (at least annually) and reports of these evaluations should be on file in a central office of the institution. Provision should be made for regularly apprising residents of the faculty's evaluation of their progress. This feedback is essential. Evaluation reports should be utilized to verify that residents are ready to graduate and be certified as prepared for Board examinations.

b. Evaluation of Readiness for Increased Patient Care Responsibility. A fundamental educational technique of graduate medical education is caring for patients in a carefully supervised setting. As residents achieve increasing knowledge, skills and judgement, increased responsibility for making decisions and providing services is necessary. Faculty supervision of residents is an important and intricate matter. On one hand, failure to allow residents to grow into increasing responsibility inhibits their professional development, while on the other hand, permitting premature assumption of responsibility endangers patients and may encourage the development of undesirable attitudes and behaviors which will

prove detrimental far beyond the training years. This difficult problem of matching responsibility with achievement cannot be resolved by arbitrarily assuming that after fixed periods of time in a program, all residents are ready for similar levels of responsibility. Verifiable and auditable methods of determining readiness for the next level of patient-care responsibility should be developed. These may include reports of direct observations of residents in the patient-care setting by several faculty members, audits of a resident's patient records, the use of simulation techniques, and written or oral examinations to determine knowledge. Specific and measurable criteria should be determined in advance in order to achieve optimal evaluation.

3. Graduation

Certification that an individual is prepared for independent patient-care responsibility is a dual function shared by the graduate medical institution and the Boards. Graduation should be acknowledged by the awarding of a certificate which signifies that the entire faculty recognizes that the individual awarded the certificate has met all of the requirements set forth by that faculty. The institution should place the same stress on its public accountability for the awarding of such a certificate as do institutions of higher education in awarding advanced degrees.

Examination by the appropriate specialty board completes the certification procedure.

4. Resident Counseling

An advising and counseling service should be available to graduate medical residents.

D. CURRICULUM AND THE LEARNING ENVIRONMENT

1. Curriculum Development

It is recognized that each graduate discipline in medicine has its special body of knowledge and skills. Nevertheless, it is not necessary that all graduate programs in a discipline have either identical content or identical requirements for length of training. Broad guidelines indicating the expectations of achievement for professionals in each discipline are achieved through a national consensus and promulgated by the Boards. Program directors, faculty and residents are encouraged to develop their own curriculum for each discipline taught within the institution and to experiment with the development of new disciplines which can provide patient care more effectively.

In developing curricula, careful attention should be paid to the special distinctions which make each resident unique. These include prior educational background and cognitive, perceptual and manual skills. Opportunities should be provided to residents to plan a significant portion of their programs with the advice and counsel of faculty.

Effective performance in any specialized discipline of medicine is founded upon general knowledge and skills common

to all physicians. Undergraduate medical school curricula are designed to provide students with these basic skills. However, if residents have not had a sufficiently broad experience in the general clinical areas relevant to their specialty, this type of experience should be provided. The timing when residents in various disciplines achieve optimal basic knowledge and clinical skills is of lesser importance than ensuring that these skills are achieved before the residents are certified for graduation.

2. Balancing Service and Education

It has been repeatedly emphasized that graduate medical education is based upon the provision of personal health care services to patients. A willingness to serve patients is an important professional attitude for physicians. The obligation to provide patient services must be a part of the learning experience for all residents. Graduate medical residents are expected to assume increasing service loads as they grow and mature into their full professional roles, and must therefore willingly accept the responsibility of serving the needs of patients in all settings. This emphasis on patient service must not be construed as condoning excessive dependence by institutions upon residents and clinical fellows for the provision of patient services.

3. Continued Intellectual Growth

While learning in the setting of direct patient care is important in graduate medical education, it is essential to

balance the educational strategy with a similar emphasis on continued intellectual growth in biomedical knowledge. Residents should be taught how to continue to expand their fund of knowledge in an organized fashion while fulfilling the demands of accepting increasing responsibility for patient care.

The development of a learning environment which maintains residents' interest in the basic biomedical sciences during the graduate years is both an opportunity and a challenge for the faculties of academic medical centers. Basic scientists and clinicians should work together to maintain and stimulate the intellectual curiosity of these older, now differentiating residents. The instructional techniques for this group must be especially tailored. Adherence to the techniques which are effective for undifferentiated, undergraduate medical students frequently will not succeed.

Centers assuming responsibility for graduate medical education should plan to support enlarged basic science faculties and should seek to recruit basic scientists who can teach effectively in the clinical setting.

E. FINANCING

1. Institutional Financing

Institutions seeking accreditation for graduate medical education must develop sufficient financial resources for supporting educational programs to ensure that administrators

and faculty with primary responsibility for education can devote their principal energies to conducting the various programs.

Because teaching and practicing clinical medicine are inextricably related, it is expected that faculty having teaching responsibilities will also care for patients. Payment for patient services delivered in the teaching setting by both faculty and advanced residents is appropriate and essential. Funds so generated should be collected and managed in such fashion that the financial needs of faculty, residents and educational programs are met effectively and fairly. This plan should be formally established, agreed to by the faculty, and its administration should be periodically reviewed by the governing board.

Residents and faculty both contribute to the services provided patients by hospitals. Hospitals providing facilities for graduate medical education must, therefore, contribute to the budget for graduate medical education.

2. Resident Financing

Because the graduate education and training of residents is long and the intensity of their responsibility precludes their earning extra income, the costs cannot be borne solely by most residents.

Residents, as they advance through their training, provide essential services to patients both on behalf of hospitals and their physician-teachers. The financing of resi-

dents should recognize these services, and income derived from both hospital charges and professional fees should be budgeted for their stipends.

F. GUIDELINES CONCERNED WITH RELATED ISSUES

1. Patient Records

Effective learning and effective evaluation of the learner in the clinical setting are dependent upon the excellence of patient record systems. Academic medical centers should make every effort to maintain high quality patient record systems. The goals should be:

a. To make the patient record an effective instrument for ensuring excellence in the provision of care to each individual patient.

b. To make the patient record an effective instrument for learning by displaying all data legibly and in a manner which assures that the rationale for each decision is clearly evident.

c. To make the patient record an effective instrument for evaluating the quality of performance of the resident by making the records auditable. Accomplishing an audit should not require extraordinary investment of time by the reviewer.

An optimal learning environment requires that the learners and their teachers participate directly in patient care and record their observations, opinions and decisions directly in the patient record.

2. Attitudinal Development

Graduate medical education has developed because of the need to provide specialized knowledge and skills to physicians in delimited areas of medical practice. This thrust has placed an emphasis on the attainment of such knowledge and skills, often to the exclusion of cultivating a professional awareness of the emotional needs and cultural characteristics of patients as individuals or as members of specific populations. Graduate medical institutions should be aware that an essential portion of their educational mission is the maintenance and cultivation of helping attitudes in their residents. Many institutions have available to them faculties in the behavioral sciences. These faculties are showing an increasing interest in participating in medical education and they should be encouraged. However, the faculty responsible for graduate medical education must assume primary responsibility for maintaining and cultivating an awareness of the physician's responsibility for encompassing all facets of patients' needs--physical, emotional and cultural.

3. Education With Other Health Professionals

Increasingly, physicians are dependent upon the knowledge and skills of other health professionals. Optimal provision of personal health services to an expanding population with increasing expectations for health care can only be met by the efficient utilization of all available talent. The period of graduate medical education provides special opportu-

nities for training physicians to work with other health professionals. Most academic medical centers are educating several types of health professionals other than physicians. In developing educational policy, curriculum, and instructional plans, members of the faculty responsible for other health professional programs should be consulted; and mechanisms for their meaningful input should be developed. In the graduate setting, differentiating physicians should learn to work with students in other health professions in the real context of patient care. Having residents develop an understanding of the special abilities of other health professionals, coupled with learning how to delegate responsibilities to those colleagues, should be a major goal.

4. Primary Patient Care

An emphasis on specialism in American medicine has resulted in a graduate medical education system focused principally on educating and training physicians for highly specialized roles in the treatment of disease. The generalist, prepared to assume primary responsibility for patients, has not received major attention. Institutions for graduate medical education are encouraged to experiment with the development of delivery systems and educational programs which will encourage a significant proportion of their residents to develop careers as primary care physicians.

5. Manpower Distribution by Specialty and Geographic Location

a. Specialty distribution:

Academic medical centers should plan their program in graduate medical education in accord with specialty manpower needs of both their regions and the nation. In a nation which is undergoing significant changes in its health care delivery system, projecting manpower needs requires complex planning technology. The geographic mobility of physicians further complicates local and regional forecasting. Institutions are urged to utilize resources available locally in developing manpower projections and to cooperate in national efforts to estimate the types of specialists needed in medicine.

b. Geographic distribution:

Solving the problems of getting physicians to settle and work in medically underserved areas is complicated. While there are many financial and cultural factors which influence physicians in their decisions for location, the professional experiences provided during their graduate education may be influential. Learning while caring for patients in well-run ambulatory settings remote from the acute-care teaching hospital may provide insights into the feasibility of establishing a practice in more remote areas. By extending graduate education opportunities into remote settings, academic medical centers will also provide opportunities for continued participation in medical education by physicians who choose to establish their practices in these areas.

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THE GRADUATE MEDICAL EDUCATION COMMITTEE

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FOREWORD

The Ad Hoc Committee on Continuing Medical Education was charged with advising the Association of American Medical Colleges regarding the role that the Association and its constituents should play in continuing education in the future. Implicit in that charge was the view that continuing education has not been effective in accomplishing its imputed purpose--to make physicians of all ages optimally effective in the performance of their professional duties.

Data on performance of physicians (including those holding full- and part-time academic appointments) are difficult to acquire, but the information available suggests that there are significant defects in performance. In the opinion of the committee, there are two main reasons for these deficiencies which are of importance to medical faculties.

The first is that the behaviors imparted during the academic years do not, apparently, persist long into the practice years. The pressures of practice envelop the physician before he has an opportunity to adapt to the discipline required to continue his learning.

Secondly, despite a complete lack of evidence of effectiveness, the "shotgun" approach continues to be the pattern of continuing education as provided by medical faculties and associations. The committee questions the effectiveness of short courses, audio-tapes, video-tapes, and even books and

journals when they are considered in the light of the documented behavioral changes experienced by the majority of physicians after they become involved in the delivery of health care.

Measurements of continuing education, such as certificates of attendance, recognition rewards, and possibly recertification and relicensure by examination, are not measurements of the end objective--improving patient care by changing the behavior of physicians--and have no greater correlation with this objective than do grades and class rankings in medical school with performance during clinical graduate training.

Therefore, it is the thesis of this committee that continuing education cannot and should not be separated from the initial formal education and that medical faculties must strive to incorporate into the basic and graduate training years those continuing education methods which have been shown to be effective.

The committee report develops this position and also emphasizes that the AAMC and its constituents must make plans for instituting educational policies which bear directly on the problem of making physicians continually responsive to the changing knowledge and technology of medicine in the context of their daily responsibilities for patient care.

INTRODUCTION

The committee determined that fulfilling its charge required that it consider continuing education not in the context of the past or present but in the context of future. There was a consensus that there will be increasing expectations by the public for professional accountability (that is, that high quality care be obtainable at reasonable cost).

A modified Delphi technique was utilized to obtain opinions of the entire committee regarding the trends and characteristics of the health care delivery system during the next 10 years.

In the aggregate the committee believes that:

1. Physicians will continue to have the major responsibility for patient care, although they will be increasingly associated with and assisted by other health professionals.

2. Group practice will increase until by the end of the decade at least 50%--and perhaps as high as 80%--of all physicians will be members of organized medical groups.

3. These groups will increasingly be associated with a specific hospital.

4. Forty to seventy percent of physicians will receive at least three-fourths of their professional incomes from salaries.

5. There will be systematized methods of assuring an acceptable quality of physician performance. The responsibility for defining accountability will be shared by:

(a) practicing physicians and medical educators,

(b) the federal government,

(c) third-party insurance carriers, and

(d) consumers.

The committee believes that the definition of the parameters of quality will be predominantly initiated by practicing physicians and medical educators.

6. Efforts to control quality of medical practice will include:

(a) Audit systems such as the Professional Standards Review Organizations already enacted into law.

(b) Relicensure and recertification with recertification being distinctly favored.

(c) Periodic updating as a condition for continued employment in both private and public clinics.

(d) Requirement for continuing education credit even though there is little evidence that this is effective in assuring that physicians will responsibly modify their practice as knowledge and technology advance.

7. With increased demand for public accountability, there will be an increasing emphasis on educational programs for physicians by hospitals and clinics.

The committee's recommendations must then be interpreted with the knowledge that medical practice in the future is expected to be conducted by physicians predominantly working in organized groups with the majority rewarded through a salary in a social system demanding accountability for control

of quality and with hospitals and professional organizations placing an increasing emphasis on staff education.

RECOMMENDATIONS

1. The medical faculty has a 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 throughout their professional lives.

The form in which students and physicians will be asked to demonstrate competence will vary as their careers evolve. Initially, written cognitive examinations will play an important part in evaluation; but these will become less frequent as skills, attitudes, and ability to deduce appropriate conclusions from given data are tested. In practice the quality of care actually being delivered may be the method by which physician competence is constantly monitored.

2. 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.

Before educational goals can be defined and plans laid, it is essential that the real educational needs of physicians be identified. Needs must relate to specified deficiencies

in knowledge, skills, attitudes, and medical care delivery organizational structures which are impairing optimal patient care. This effort cannot be unilateral. The academic staff must be as willing to examine and correct its own deficiencies in patient management as it is to criticize management by members of the nonacademic community of physicians. Students must see that their mentors are willing to participate in rigorous criticism of their own clinical activities. The development of positive and responsive attitudes of open dialogue among physicians must be imprinted as early as possible. Faculty examples of disregard of criticism may be a significant factor in imprinting and molding later regressive behaviors in physicians, impairing their willingness to participate in lifelong learning.

In developing criteria, both the processes of patient care and outcomes must be scrutinized. Although the patient population and the mission of academic hospitals vary from nonacademic hospitals, the committee urges that equivalent standards for ensuring optimal quality be required for all health providers in a community.

Initially, both the establishment of criteria and the development of a feedback system must be modest in scope, but ultimately criteria for all disciplines and subdisciplines of clinical medicine should have a systematized methodology. The areas where the efficacy of two or more approaches to the same problem is unresolved must be identified and flexible allowance made for differing professional opinions.

3. Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected through systems developed for accomplishing recommendation 2. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.

There is too often an undue preoccupation with form which obscures function in continuing education. The development of educational programs should be directed toward fulfilling the physician's own desire to improve his performance as rapidly and as effectively as possible. Consideration should be given to principles of adult education concerning variations of learning styles, objective-directed learning, and the necessity for interchange of ideas during the learning process. Where learning new skills requires an on-the-job setting, provisions should be made to bring physicians to the appropriate site for the needed period. This may require the provision of substitute personnel in the physician's practice; the academic centers are urged to work particularly with organized groups that have planned for this need.

4. Evaluation of the effect of educational programs should be planned from their first inception. Evaluations should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day-to-day practice. Depend-

ence upon subjective evaluation of participants and/or cognitive evaluation may be spurious and misleading.

Experimental protocols and research applications failing to provide methods for data collection would not survive any current scientific review process. So too, with educational exercises at undergraduate, graduate, and continuing education levels, there should be methods for assessing objectively that specific desired learning outcomes have been achieved. As the student progresses in his professional education and career, these methods become increasingly sophisticated, time-consuming, and expensive but are, nevertheless, critical to the success of the educational system. Continuing education should be looked upon as a pragmatic effort to improve professional practice and can thus only be evaluated in the real practice setting. If the deficiencies toward which an educational program was directed persist, the content, mode of presentation, and motivational impetus for the learners must be re-examined.

Recommendations 1 through 4 set forth the broad principles upon which the committee believes the Association and its constituents should base their efforts in continuing education. The subsequent recommendations are directed toward specific areas of concern.

5. *Medical faculties should evolve auditable records.* Assessment of both the process and outcomes of patient

management requires a written clinical record which clearly sets forth the problems identified and attacked, the logic of the diagnostic and therapeutic decisions made, and the outcomes of these decisions. Academic faculties are encouraged to evolve clinical record systems which meet these needs. Students should learn from their very first clinical experience how to develop such records and should grow to expect that their records will be reviewed throughout their professional lives. Faculty willingness to accept review and criticism from colleagues in their own and other disciplines is essential for inculcating responsible professional attitudes in the students whom their attitudes influence. A uniform patient record system involving all affiliated institutions in a center would greatly assist in education and in the measurement of the quality of patient care.

6. *Medical faculties should endeavor to apply computer technology to patient record systems, diagnostic and therapeutic decision-making, and educational feedback systems.*

Computers have undeveloped potential for clinical data management in a real time sense. Notable experiments are in process, and much can be learned from these. Resistance to the application of computers to clinical problems and adherence to the handwritten records of the past is a position which must be carefully reassessed. Because of high costs for both developmental and operational computer applications, resource sharing among centers will be essential.

7. Educational planning and implementation should be carried out with the direct involvement of individuals skilled in educational methodologies.

The development of systems for establishing patient management criteria and educational goals and objectives and for evaluating the impact of education on the learner require skills not necessarily inherent in all medical academicians. Both initial and continuing education require the assistance of individuals who may or may not be physicians but who have had the necessary training to develop and implement modern, goal-directed educational programs. The services of these individuals will do much to improve medical education throughout its continuum.

8. Whenever appropriate, the members of a health team should be educated together.

As the team concept of patient care grows, management and skills of delegation are becoming more important. Educational programs directed toward the improved attainment of team care should be developed and directed toward the activities of the entire team. Interdisciplinary development of criteria of quality of care is a method by which educational programs in which the team members learn together may be encouraged.

9. Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.

Continuing education must be financed from several sectors. Traditionally, these programs have been self-supporting. The process of evaluation of the efficacy of programs in terms of altered physician behavior and/or improved patient care is sophisticated, time-consuming, and expensive. As with any other sector of education, stable base funding from states, professional societies, and the federal government is essential in order to ensure the development of a skilled cadre of individuals to direct, lead, and evaluate such programs.

The committee believes that education of health professionals, and particularly their continuing education, must be directed toward the goal of the constant improvement of health care throughout the nation. Special funds, obtained on a competitive basis, are necessary in order to stimulate the development and implementation of new ideas in this area. Tuition derived from the students must also be continued in order to both provide support for ongoing programs of proven worth and to create an attitude of personal investment by the learner.

CONCLUSION

These nine recommendations do not represent extraordinary departures. All of them have been developed and implemented to varying degrees both in academic centers and in community hospitals. They do not set continuing education apart from the formal academic programs for students still in their

medical school or clinical graduate years but rather attempt to meld these years into the full professional life span.

The recommendations are pragmatic and are based upon defensible predictions of the characteristics of the health care system during the next decade. If the AAMC and the academic centers embark upon policy development which implements these recommendations in a spirit of cooperation with practicing physicians, much of the criticism currently being leveled at the health care system may be allayed.

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III. Action Items:

3. Selection of Nominating Committee:

The Nominating Committee consists of seven members. The Committee is chosen by mail ballot to CAS representatives from a list of 14 representatives prepared by the Administrative Board. Page 9 of the CAS Rules and Regulations describes the selection and functions of the Nominating Committee. Please be prepared to develop a list of 14 names for the Nominating Committee ballot.

AAMC RMP-CHP LEGISLATIVE PROPOSAL

At a May 1972 meeting of the Association's Health Services Advisory Committee, John A.D. Cooper, M.D., AAMC President, proposed the establishment of an ad hoc committee to consider the implications for the Association in connection with the legislative authorizations for the Regional Medical and Comprehensive Health Planning programs, which expire June 30, 1973.

Committee membership included Dr. Stuart Sessoms, chairman; Dr. William S. Jordan Jr.; Dr. Alexander M. Schmidt; Dr. William Stewart; Dr. James V. Warren; Dr. William R. Willard; and Dr. Andrew Hunt. The committee was asked to give consideration to the following issues:

1. What do RMP and CHP do now, and how does that affect the Association constituency;

2. What does the Association think RMP and CHP should do, and how should that affect the Association constituency; and

3. What steps would be necessary to achieve this, with particular reference to a possible legislative proposal.

The committee has held a number of meetings, has questioned numerous experts in the field, and has received assistance from the Association staff, including reports on site visits to a number of CHP and RMP programs or agencies. Among the persons who appeared before the committee were John R.F. Ingall, M.D., Director, Regional Medical Program of Western New York, representing the RMP Coordinators Association; and Mr. Larry Newell and Mr. William Hiscock, representing the American Association of Comprehensive Health Planning. The major findings and conclusions of the committee are represented in the accompanying Outline of Proposed Legislation.

In essence, the Association's legislative proposal is based on the following principles:

1. There should be established a Council of Health Advisers in the Executive Office of the President to advise him on national health policy, on preparation of appropriate legislative proposals, and on preparation of a biennial Report on the Nation's Health. The Council should be assisted by a National Advisory Commission on Health Planning.

2. There should be established a program of grants to states for health planning and services which would be carried out by state health agencies which, in turn, would be comprised of a planning unit (providing comprehensive health planning at both the state and area level) and a health services unit (combining a number of existing federal health service development programs, the most important of which is RMP). The principal function of the health services unit should be to support programs to tranfer more effectively the advancing knowledge in medicine and biomedical technology from the academic health centers to the practicing community. Block-grant financing should be provided through allotments to states of federal funds for health planning and health services. Public participation should be provided through appropriate advisory groups. State health planning and services should be required to meet federal standards

which the HEW Secretary would develop with the review and approval of a National Advisory Council on Health Planning and Services.

3. There should be a focus at the federal level on health services research and development which would be accomplished by providing for a permanent, open-ended authorization of appropriations for the National Center for Health Services Research and Development, whose authority is to expire June 30, 1973.

It is hoped that the Executive Council will study and comment on the Outline of Proposed Legislation, which follows, and take the following action.

RECOMMENDATION

It is recommended that the Executive Council adopt the principles listed above as Association policy on the extension of RMP-CHP legislation.

Outline of Proposed Legislation

Title I

Council of Health Advisers

Require the President to submit to Congress a biennial Report on the Nation's Health which shall include information on the status of the nation's health; on trends in the quality, management and utilization of health services; on the adequacy of the nation's health care resources; on the effect of government programs in the nation's health; and on methods or legislation for meeting identified deficiencies.

Establish in the Executive Office of the President a three-person Council of Health Advisers, comparable to the Council on Environmental Quality.

Authorize the Council to employ necessary officials and to fix their salaries, and also to employ necessary experts and consultants.

Specify the duties and functions of the Council --

(1) to assist and advise the President in the preparation of the Report on the Nation's Health;

(2) to gather timely and authoritative information concerning the conditions and trends in the nation's health both current and prospective, to analyze and interpret such information for the purpose of determining whether such conditions and trends are interfering, or are likely to interfere, with the improvement of the nation's health and to compile and submit to the President studies relating to such conditions and trends;

(3) to review and appraise the various programs and activities of the federal government for the purpose of determining the extent to which such programs and activities are contributing to the improvement of the nation's

health, and to make recommendations to the President with respect thereto;

(4) to develop and recommend to the President national policies to foster and promote the improvement of the nation's health to meet the social, economic, health, scientific, ethical, and other requirements and goals of the Nation;

(5) to conduct investigations, studies, surveys, research, and analyses relating to health care resources and health services delivery;

(6) to document and define changes in the health of the nation and to accumulate necessary data and other information for a continuing analysis of these changes or trends and an interpretation of their underlying causes;

(7) to report in alternate years to the President on the state and condition of the nation's health; and

(8) to make and furnish such studies, reports thereon, and recommendations with respect to matters of policy and legislation as the President may request.

Establish a 19-person National Advisory Commission on Health Planning to assist and advise the Council, which shall be composed of five members appointed by the President protempore of the Senate, five members appointed by the Speaker of the House, and nine members appointed by the President.

Require the Council to consult with the National Advisory Commission on Health Planning and to utilize other, nongovernment resources as appropriate.

Provide that the members of the Council shall be full-time employees and fix their pay rate in the Executive Schedule.

Authorize appropriations to carry out the title of $300,000 in fiscal 1974, $700,000 in fiscal 1975, and $1,000,000 in fiscal 1976.

Title II

Health Planning and Services

Findings and Declaration of Purpose

Describe the general need for the legislation and the purposes for it --

(1) promote the establishment of more efficient and effective health service systems, assure coordination among all federal health programs, as well as with other health related programs and activities, and with particular attention to the relationship between improved organization and delivery of health services and the planning thereof;

(2) assist in the support of state programs of health planning, public health services, the initial support of new health services, and the support of health services meeting particular needs;

(3) provide support for research and development (including demonstration and training) related to improving the organization, planning, and delivery of health services; and

(4) provide support for demonstrations and experiments in the integration and coordination of federal health programs, and appropriate related programs, leading to the development of improved health systems extending high quality care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by federal health programs.

Grants to States for Health Planning and Services

Describe conditions to be met in order for a state to be eligible for assistance under the section: designation of a state agency to carry out the state's health planning and health service assistance functions (with

the option at the Secretary's discretion of separate agencies being so designated); provision for a state health planning and service assistance advisory council, a majority of whose membership shall be health care consumers; provision of assurances to the Secretary that the state agency will have authority to carry out its functions and that federal funds will increase state health spending rather than supplant it; provision of appropriate methods of administration, fiscal controls and reporting procedures. Provide that interstate compacts may also qualify for assistance.

State Health Planning

Describe the state health planning function. Planning shall be conducted according to criteria established by the Secretary and shall give first consideration to identification of acute problems and development of means to overcome them. State health planning shall be carried on in cooperation with education, welfare and rehabilitation agencies. State health planning shall include the relationship between the health needs of the people and the capability of the health care system to deliver health services; the development and distribution of health personnel; the establishment of methods of measuring the quality of health care provided in the state; and the evaluation of health care planning and services in the state. The state health planning agency shall review and approve applications for all health related projects in the state to be assisted under the Public Health Service Act, the Social Security Act, or other appropriate provisions of law, except that it shall not consider applications related to biomedical research or health professions education. Require the state planning agency to review its plans at least annually. Require the state health planning agency to work with health care facilities in the state on a capital expenditure program. Require the Secretary to carry on a continuous program of health service planning in consultation with state planning agencies and provide for federal takeover of state health planning if the

state agency does not carry out its responsibilities. Exclude planning with respect to the national supply of professional health personnel from the general emphasis on state-by-state planning.

State Health Service Assistance

Describe the state health service assistance function. The state health service agency shall be responsible for providing adequate health services to the people of the state. Services assisted or provided shall meet criteria as to their scope and quality prescribed by the Secretary and shall be in accordance with state health plans. If a state designates separate planning and assistance agencies, then the approval of the planning agency must be obtained prior to approval of a project by the service assistance agency. The priority of projects to be assisted is to be based on the relative need as determined in the state health plan. Except for assistance with respect to the national supply of professional health personnel, health services assistance shall proceed primarily on a state-by-state basis. If the designated state agency does not carry out its responsibility, the Secretary shall assume responsibility for coordinating the service assistance functions within the state. Applications for health services assistance may be made by any public or nonprofit private entity or combination. No application shall be disapproved by the state action agency until the agency has afforded the applicant an opportunity for a hearing. The state health service assistance agency may make grants or enter into contracts for any of the purposes currently provided for in existing Public Health Service Act sections 304 (health services research and development); 314(e) (health services development); 904 (establishment and operation of RMPs); 910 (multiprogram services); 314(d) (public health services).

State Allotments and Payments to States

Provide for the allotment of appropriated funds to states on the basis of the population, per capita income, and the extent of the need for

health service assistance, provided that no state would receive less than one percent of the appropriation. Funds may be reallotted by the Secretary if not fully used by the state to which they were initially allotted. From each allotment, the state shall be paid from time to time the federal share of expenditures incurred in carrying out the state's health planning and health service assistance functions. The federal share is to be 90 percent for states which designated a single agency to carry out the two functions, 75 percent for states which designated separate agencies, and 80 percent for states with separate agencies but also with certificate of need legislation.

Project Grants for Areawide Health Planning

Provide for project grants by the state health planning agency to other public or nonprofit private agencies or organizations for areawide health planning, similar to the planning currently authorized in existing section 314(b). There must be an areawide health planning council, a majority of whose membership must be health care consumers; and the areawide health planning agency is to assist health care facilities in the development of a capital spending program.

Project Grants for Training, Studies and Demonstrations

Provide permanent, open-ended authorization for project grants by the state health planning agency to any public or nonprofit private agency, institution, other organization, or combination to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward development of improved or more effective comprehensive health planning.

Withholding of Payments

Provide for the withholding of funds by the Secretary when he determines after reasonable notice and opportunity for hearing that there is a failure to comply substantially with either the applicable provisions of the law, the state health plan, or applicable regulations.

Definitions

Define terms used, including the terms regional medical program, medical center, clinical research center, hospital, nonprofit, and construction.

Annual Report

Provide for an annual report to the Congress from the Secretary on the effectiveness of the activities carried out under the legislation, on the relationship between federal and nonfederal financing for activities undertaken under this legislation, and on recommended changes in the law.

Authorization of Appropriations

Authorize appropriations of $600 million in fiscal 1974, $700 million in fiscal 1975, and $800 million in fiscal 1976 for this program of grants to states for health planning and services, and provide that no funds shall be available to pay for hospital care except in connection with research, demonstration or training carried out under the program.

General Provisions

Provide such general provisions as are necessary to make the new program of grants to states for health planning and services conform to routine Public Health Service Act and DHEW legislative requirements.

Federal Standards

Provide a mechanism under which the Secretary, with the participation and approval of the newly established National Advisory Council on Health Planning and Services, shall provide for the development of federal standards for health planning and services, in cooperation with appropriate regional, state and local review organizations as determined by the Secretary. Require state health planning and health service agencies to meet such standards. Provide for the development of interim standards, pending the development of permanent standards.

National Advisory Council on Health Planning and Services

Establish a 23-member National Advisory Council on Health Planning and Services to advise and assist the Secretary in the preparation of general regulatic

for, and as to policy matters arising with respect to, the administration of this program of grants to states for health planning and services, with particular attention to the relationship among comprehensive health planning, the improved organization and delivery of health services, and the financing of such services. The Council shall review at least annually the grants made under the program to determine their effectiveness in carrying out their purposes. The Counci is to be comprised of four ex-officio members -- the Secretary, the Chairman of the Council of Health Advisers, the chief medical officer of the VA, and a medical officer designated by the Defense Secretary -- and 19 members appointed by the Secretary, a majority of whom are to be representatives of health care consumers. The appointed members are to be selected from among leaders in the fields of the fundamental sciences, the medical sciences, or the organization, delivery and fina cing of health care, officials in state and areawide health planning agencies, leaders in health care administration, or state or community or other public affairs, who are state or local officials, or representatives of consumers of health care. The Secretary is to be chairman of the Council, and it is to meet at least four times a year. Appointed members of the existing National Advisory Council on Comprehensive Health Planning Programs (which the new Council replaces) may serve at the Secretary's discretion as additional members of the new Council until their existing terms expire.

Other Amendments to the Public Health Service Act

Amend section 304(a) (research and demonstrations relating to health facilities and services) to provide a permanent, open-ended authorization for the National Center for Health Services Research and Development.

Policy Statement of the AAMC on PSROs

TITLE XI of Public Law 92-603, the Social Security Amendments of 1972, calls for the establishment of PSROs nationwide to monitor and evaluate the costs and quality of health care for Medicare and Medicaid patients. At present, the Federal responsibility for developing this program has been divided among three agencies. HSMHA has been assigned the task of developing norms and standards as well as designing methodologies for collecting the necessary data in a uniform manner; SSA, because of its operational experience in administering the Medicare program, will assimilate the data through its EDP facilities, utilizing the capabilities of its carriers and intermediaries.

The PSRO office under the direction of the Secretary of HEW will have overall policy determination over both HSMHA and the SSA.

$10M this fiscal year and $30M next fiscal year have been requested for PSRO activities. Most of these funds will be utilized for contracts to prototype PSROs with some monies for central office operations and a small amount for research. The majority of the PSRO staff positions will be within the BHI of the SSA.

Although PSRO regulations will not be developed anytime within the near future, it is anticipated that some preliminary guidelines will be distributed for the use of "early" PSRO programs, as well as those organizations with plans to become PSROs (under Section 1169 of the Law, funds are provided for feasibility and planning grants to PSRO prototype projects).

By January 1, 1974, the Secretary of HEW will have designated the geographical areas for PSROs. Nationally there will be approximately 150-200 PSROs which will be established mostly below the state level.

The PSRO will be required to develop a series of profiles on institutions, physicians and patients. Although rudimentary patient and physician profiles now exist in the computer tapes of the intermediaries and carriers, they must be expanded to include additional data and must be collated to produce the requisite information.

Utilizing EDP techniques, matrices will be developed by PSROs which will facilitate the evaluation of practioner and institutional performance in multiple areas of health care services.

The preparation, distribution and validation of data, starting at the local level and channelled through the PSRO central office and back to the local organizations will constitute a substantial administrative task to be performed by the 100 carriers and intermediaries for Medicare and a large number of different carriers and intermediaries for Medicaid. Changes will also have to be made in the present EDP system of the SSA to accommodate the demand for additional and different types of data.

Within the teaching hospital, the U.R. Committee could be used as a mechanism for developing an internal review system to meet the operating requirements of the local PSRO. If the norms, criteria and standards developed by the U.R. Committee are judged to be acceptable to the PSRO, the hospital can then be made responsible for reviewing its own health

care services subject to periodic sample auditing by the PSRO. In such cases, the U.R. Committee can make decisions in regard to patient care which are binding upon the carrier as well as the SSA.

Records and data will have to reviewed to determine such things as appropriateness of admission, parameters of acceptable care for various disease states and perhaps comparison of surgical rates, for example, of hysterectomies and tonsillectomies with those of other hospitals in the area.

With the realization that the PSRO legislation needs to be more clearly interpreted, the Federal Government may develop a PSRO Model Review System to describe how a PSRO could be organized. This package would include a model charter, by-laws, membership guidelines, a budget, an appropriate data system and a reporting mechanism. The early directives to be distributed with this package could suggest the types of activities that should be conducted by a PSRO, e.g. pre-admission certifications program, development of a model treatment plan, etc.

In developing their programs, PSROs will be assisted by the technical and regional staffs of HSMHA and SSA. Once geographical areas have been designated, it is recognized that institutions such as teaching hospitals will require additional staff and resources to assist their U.R. Committees in meeting the requirements of the local PSROs.

The Association's Subcommittee on Quality of Care (Dr. Robert Weiss, Chairman; Dr. Clement Brown; Dr. David Challoner; Dr. Christopher Fordham; Dr. Richard Meiling; and Mr. John Westerman) will meet in April to develop further the AAMC's relationship to the evolving federal presence in quality and cost review.

The Subcommittee intends to meet with Dr. Bauer, Director of PSRO, and the Senate Finance Committee staff, and develop recommendations for teaching hospitals to meet PSRO criteria through multiple mechanisms. In addition, the dissemination of information, where teaching hospitals have successfully worked out mechanisms with prototype PSROs, will be one of the major goals of the Subcommittee.

Approval by the EC of a policy statement on the appropriate involvement of the AAMC membership in the development of PSROs is desirable at this time.

RECOMMENDATION

It is recommended that the Executive Council approve the following statement as an AAMC policy on PSROs:

> 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 schools and teaching hospitals. A major part of this responsibility is the incorporation of quality-of-care assessment into clinical educational programs to develop in medical students a life-long concern for quality in their practice.

The AAMC, therefore, strongly recommends that its member institutions become intimately involved in the development and operation of Peer Standards Review Organizations.

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

   X YES ____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested:

   501 (c) 3

3. If request for exemption has been made, what is its current status?

   X a. Approved by IRS

   ____ b. Denied by IRS

   ____ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

_____
(Completed by - please sign)

_____
(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mary Xxxxxxxxxxxx~~ Connie Choate

NAME OF SOCIETY: AMERICAN COLLEGE OF CHEST PHYSICIANS

MAILING ADDRESS: 112 East Chestnut Street, Chicago, Illinois 60610

PURPOSE: (1)To maintain and international society of highly qualified specialists in cardiovascular and pulmonary medicine and surgery and related disciplines; (2)To promote the highest possible standards in clinical practice, education and research in cardiovascular and pulmonary medicine and surgery and related disciplines; (3) To cooperate with medical schools and other scientific organizations and societies in providing the best possible undergraduate instruction in cardiovascular and pulmonary medicine and surgery and related disciplines; (4) To provide high quality educational programs designed to maintain and advance the highest possible standards of medical practice as it pertains to cardiovascular and pulmonary medicine and surgery and related disciplines; (5) To promote cooperation with other organizations the highest possible standards in allied health professions and services; (6) To be concerned with problems of public welfare related to the specialty interests of the College.

MEMBERSHIP CRITERIA: Please see attached brochure containing membership requirements.

NUMBER OF MEMBERS: 6131 United States and Canada; 2703 other countries. 8834 total.

DATE ORGANIZED: August 1935

SUPPORTING DOCUMENTS REQUIRED (Indicate in blank date of each document):

October 27, 1971 1. Constitution & Bylaws

_____ 2. Program & Minutes of Annual Meeting
Advance program for October 1972 and Minutes of October 1971.

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

   X YES ____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested:

   Section 501 (c) (3) Internal Revenue Code of 1954

3. If request for exemption has been made, what is its current status?

   X a. Approved by IRS

   ____ b. Denied by IRS

   ____ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Alfred Soffer M.D.
(Completed by - please sign)
Alfred Soffer, M. D., Executive Directo

July 31, 1972
(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mary Hxxbittxxxxxx~~ Connie Choate

NAME OF SOCIETY: American Society of Therapeutic Radiologists

MAILING ADDRESS: c/o Luther W. Brady, M.D., President
American Society of Therapeutic Radiologists
Hahnemann Medical College and Hospital
230 North Broad Street
Philadelphia, Pennsylvania 19102

PURPOSE: The American Society of Therapeutic Radiologists is an organization of physicians specializing only in therapeutic radiology. Its efforts are directed to benefit the patient by promoting the highest possible standards of therapeutic radiology, by improving the training of therapeutic radiologists and by providing clinical and laboratory researches into the frontiers of knowledge of the specialty.

MEMBERSHIP CRITERIA: Active membership is available to physicians in the Americas who specialize fulltime in therapeutic radiology. Associate membership is available for qualified radiation physicists, radiobiologists, and other specialists with recognized interest in the aims of the Society. Junior membership is offered to residents in training in therapeutic radiology. Corresponding membership shall be open to residents of foreign countries who fulfill the requirements for active or associate membership but cannot attend regularly the functions of the Society.

NUMBER OF MEMBERS: 700

DATE ORGANIZED: In 1958, the society was originally organized as a club and assumed status as a separate society in 1966.

SUPPORTING DOCUMENTS REQUIRED (Indicate in blank date of each document):

March 1971 1. Constitution & Bylaws

October 1971 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

   X YES ____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested:

   Sec 501 (C)(3)

3. If request for exemption has been made, what is its current status?

   ✓ a. Approved by IRS

   ____ b. Denied by IRS

   ____ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

   [signature]
   (Completed by - please sign)

   3/31/77
   (Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mary Hartman~~ Connie Choate

NAME OF SOCIETY: AMERICAN UROLOGICAL ASSOCIATION, INC.

MAILING ADDRESS: 1120 North Charles Street
Baltimore, Maryland 21201

PURPOSE: (a) To encourage research, experiments, investigations and analyses of diseases, abnormalities and other conditions of the genito-urinary tracts, their treatments and corrections, and to make the results known to physicians and the public.

(b) To develop, and assist in developing, scientific methods for the diagnosis, prevention and treatment of such diseases and to make the results known to physicians and the public.

(c) To benefit the general public by encouraging the study and maintaining the highest possible standards of urological education, practice and research.

(d) To promote the publication of and encourage contributions to, medical and scientific literature pertaining to urology.

MEMBERSHIP CRITERIA:

See pages 8 - 14 of the Constitution and Bylaws, May 1972

NUMBER OF MEMBERS: 3,125
# of faculty members:
DATE ORGANIZED: 1902

SUPPORTING DOCUMENTS REQUIRED (Indicate in blank date of each document):

May 1972 1. Constitution & Bylaws

May 1972 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

✓ YES ___ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested:

501 (c) 3

3. If request for exemption has been made, what is its current status?

✓ a. Approved by IRS

___ b. Denied by IRS

___ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

D. W. Kennedy
(Completed by - please sign)
President, AUA
August 8, 1972
(Date)

IV. Discussion Items:

1. Activities related to the Administration Budget proposals.

The immediate and future impact of Administration budget proposals for FY 1974 are of major concern to the constituency. You have received a document entitled, "Survey of Administration Health Budget proposals--Guideline Information," dated February 16, 1973. This document provides the most complete, up-to-the-minute information regarding funding levels and agency strategies for modifying or phasing out programs. A questionnaire has been sent to all the schools. Some information from the schools may be available by March 15. Another questionnaire has been prepared for six major disciplines (Medicine, Pediatrics, Psychiatry, Microbiology, Physiology, and Biochemistry). The status of that study will be reported. A considerable portion of the Administrative Board meeting will be devoted to discussion of plans, strategies and tactics for the FY 74 appropriations debates.

AN APPROACH TO SUPPORT OF POSTDOCTORAL TRAINING

By David R. Challoner, M.D.
Department of Medicine
Indiana University Medical Center

The Administration recently announced the termination of the Training Grants Program of the National Institutes of Health. The reasons given included an unsupported estimate that the present supply of scientists would equal demand for the foreseeable future. This discussion will not deal with this issue, though most available data would refute this contention (1). I would suspect that the most compelling arguments to the Administration were rather, as they further stated: "In view of improved supply/demand balance in research manpower, it seems appropriate now to rely on the normal mechanisms in the professional manpower market to produce any additional manpower needs. The income expectations of doctoral level scientists are such as to make it appropriate to expect them to bear the costs of their training themselves. Amounts secured through loans can be repaid from adequate salaries after training is completed. Those trainees who need financial aid should look to the general programs available for student assistance through the Office of Education or other scholarship sources" (2). This philosophical approach reflects this Administration's general thrust that the costs of training should be born by those who benefit economically, with direction being from normal market forces (3). Most of us would consider

such a proposal both too simplistic and naive, since one of the major problems in biomedicine is the absence of normal market forces. For instance, we have a seemingly completely elastic demand for clinical services created in part by the deliverer himself. Moreover, in personnel development there are tremendous time lags between demand and supply. Thus, the Administration invokes "free market" on the one hand, while considering controls or "assistance" to the free market in the clinical area on the other. What might the absence of Training-Grant support mean to the "free market" decision of the potential trainee? Even with the Training Grant it is difficult for the M.D.-scientist at age 32, with wife and young children and a debt of $15,000, accumulated before the fellowship years, to face a decision to stay in academic medicine and research at $25-35,000 vs. the $50,000 and up available in private practice for this select group. Given the absence of training grants, this could add $10,000/year further to this debt almost assuring the loss of this select resource to research and teaching. Though this same dilemma does not exist in the Ph.D. programs, the huge debt incurred when considered against the good but not extravagant future incomes would be discouraging to all but the wealthy.

Yet to this writer, there is still some compelling logic in the position that training which increases one's future economic well-being should, at least in part, be born by the trainee.

This has not been the case in the Training Grant Programs in the past (unless one wished to attempt to account for foregone income) and this is a major objection of the Administration.

AN ANALYSIS

The following discussion is an attempt to identify the beneficiaries of biomedical postdoctoral clinical and research training programs with a subsequent suggestion of an allocation of costs in accordance. Perhaps such a discussion will allow us to develop a program which could attract broad support in both academic and government circles and avert the present danger of "throwing out the baby with the bath water."

Though the biomedical trainee certainly benefits from his training, he is by no means the exclusive beneficiary. Both economists, such as Fein (4) and social thinkers, such as Millis (5) make this point. "The beneficiaries of medical education are the individual patient, society as a whole, and the physician. The patient benefits because there is a physician competent to deal with his problems of health and disease. Without a physician his well-being and welfare are greatly jeopardized. Society benefits because there can be no public welfare, no national progress, except through the well-being of its individual citizens.

The physician benefits because he is afforded the opportunity to gain a professional skill which will produce an unusually substantial reward monetarily, socially, and personally. A rational policy of financing medical education should recognize these benefits received" (5).

SOCIETY

Just as stated above for medical undergraduates, society and the general welfare are clearly amongst the beneficiaries of biomedical clinical and research fellowship training. The most appropriate means of assuming this responsibility is by direct grants in support of the trainee from the general fund exactly as in the present Training Grant Program. For purposes of simplifying the present discussion, let us assume that society should assume 20% of the cost of the training as at least equivalent to the benefits to the general welfare. Moreover, it should be remembered that the trainee ultimately contributes to the commonweal and the general fund through his income taxes in addition to his specific contributions discussed later. Further discussion of this and subsequent estimated allocations will be necessary; they have been made without extensive analysis. Whatever the percentage, it is most important to note in the present climate that this argument does not call for full Federal stipend support. Moreover,

it is imperative for academic bioscience to acknowledge that such a grant from the general fund is accompanied by a social accountability which must allow for significant control of who will be trained, where, and in what. Assuming total annual costs of $26,000 (see table), this would demand a grant of $5,200 per trainee (see table).

SERVICES

The next group of beneficiaries of the trainee's activities are the direct recipients of the Services performed by the trainee as part of his program. Some portion of almost all fellows' time is spent in teaching; in the case of clinical fellows, primarily medical students and residents; for basic science trainees this might be undergraduate, graduate or medical students. Such teaching by clinical fellows is currently only rarely compensated but clearly should be from teaching funds. It is a "pirated" service. In the basic sciences, the teaching assistantship is probably not as widespread as would be justified by the economic value of the service rendered.

Fellows in the clinical specialties provide additional clinical service to private and staff inpatients and outpatients. Because of both inertia and Federal regulation, much of this activity on staff patients is not recovered. The present argument would suggest the position that these legitimate economic services should be recoverable by the institution for whom the clinical trainee works,

especially since many of these trainees are already Board-eligible or certified in their general specialty. Additionally, it is not unreasonable for the institution to recover in some fashion a proportion of its faculties' private-patient incomes where fellows have assisted in the performance of various private-patient services. This is done all too rarely. "Moonlighting" should be discouraged.

Thus there are many sources of real and potential income-producing activities, the economic benefits of which should form a portion of the trainees' stipend. For the present argument let us assign an estimate of 20% or $5,200 to this portion. For purposes of uniformity and balance, it should be the obligation of the institution to recover, pool, and dispense these funds. Some specialties and activities could develop income with more facility than others. Most desireable for purposes of fairness to the total pool of trainees would be to set up a school-wide fund into which all teaching and clinical service monies derived by trainees would be placed for disbursement at the appropriate percent of total stipend to each trainee. Because of the previous availability of total Federal stipend support, this legitimate allocation of cost to Service with its resultant income benefits has not been made.

SELF

The third and final beneficiary is the trainee himself

who gains directly in prestige, satisfaction and, in greater or lesser degree, future income. He should fairly assume some of the cost as discussed above, but not all of the cost as contended by the Administration's incomplete analysis. In the present illustration, this responsibility of the trainee (self) would be as a 60% beneficiary or $15,600 of which an estimated $10,000 is his own foregone income to net $5,600. This is a legitimate cost allocation according to Fein (4).

The trainee, of course, might choose to provide this portion from private resources or to lower his standard of living to that provided by only the first two economic benefits, in effect foregoing further income. Or finally, he may choose to borrow.

It is at this point that one of the more unique aspects of this analysis will be discussed, a new application of an idea, relatively young but not originated by this author, The Educational Opportunity Bank (6,7,8). The application of this concept to the financing of medical education, in particular, has been strongly recommended by Millis (5), Fein (4), and the Carnegie Commission on Higher Education (9). For reasons too detailed to go into here, the present application may be an ideal well-circumscribed model to test the concept for its more general applicability and

thus increase the attractiveness of the total proposal.

Briefly the concept is as follows: The Federal Government, in this case perhaps the NIH, would be the source, if not the agent to lend, in the present case up to $5,600/year, to the trainee. The Bank would recoup these loans through annual payments collected in conjunction with the borrower's future income tax. At the time the loan was granted, the borrower would pledge a percentage of his future income for a fixed number of years. A preliminary estimate is that the bank could be self-sustaining if it charged borrowers with the prospective incomes of biomedical clinical and research trainees, 0.1 to 0.4% of gross income over 30 years for each $1000 borrowed.

Contingent repayment loans have several advantages over present fixed repayment loans.

(1) No borrower would have to worry about a large debt he could not repay; thus his decision for a high paying (private practice) vs. a lower paying (academic) future activity need not be colored by the specter of a large conventional debt, soon to be repaid. Moreover, it is unlikely that such amounts would be

available in the private or student loan market on top of previous average indebtedness of this group. Equal access to the training would be guaranteed to people of all income backgrounds.

(2) By spreading repayment over 30 years instead of 5 or 10, the Bank would make it feasible for the trainees to borrow larger sums. Current loan programs have time and dollar limits.

(3) The availability of loans would not be directly affected by the state of the money market.

(4) Since payments are based on a percentage of the borrower's income, there are minimal payments when earnings are low.

(5) The financial viability of the Bank is maintained by setting the rate at which income is taxed at a level that will yield payments by the high earners sufficient to compensate for the inability of the low earners to pay fully the principal and other costs of their loans. Thus, there would be an element of income distribution in

biomedicine, perhaps not attractive to some, but, in my opinion, realistic considering the unusual market amongst medical activities and the interdependence of each for the others skills in maintaining the profession. Moreover, it avoids the necessity of either the government to make an implied demand or the trainee to make an unrealistically early decision regarding an academic vs. clinical career.

TOTAL COST

For purposes of the discussion thus far, I have not discussed cost other than stipend as contributing to total cost. Obviously, there are other instructional costs to the institution in training a postdoctoral fellow, such as faculty time, laboratory space, and supplies. These costs must be returned to the institution (4). For this discussion, let us assume these costs to average $4,000/year. In addition, it also should be noted that foregone income is a legitimate cost to be considered (4). Assuming $22,000 to be a reasonable estimate of income alternatives to the physician-fellow, a stipend of $12,000 leaves $10,000 in foregone income (table). This cost would be less to basic science postdoctoral fellows.

RECOMMENDATION (See table.)

In summary and for discussion purposes, I would suggest that:

(1) A new training resource program be established by the NIH taking cognizance of an estimate of the economic benefits accruing to the

trainee, society in general, and the service provided by the trainee.

(2) The NIH would award the support in the numbers locations, and disciplines they desired.

(3) The support from the NIH to the institution would be approximately 20% of the total cost, reflecting an estimate of the benefit to society in general of the availability of the trainees subsequent skills, whether clinical or research.

(4) The institution, upon accepting the grant, must pledge an additional 20% of total cost which could and should be recovered from a local pool of income derived from the trainees teaching and clinical service activities. From the monies of #3 and #4 the institution pays the trainee the balance of the stipend not the trainee's allocated responsibility, and retains the balance as instructional cost.

(5) The NIH would establish an Educational Opportunity Bank, loaning an additional $5,600 or 22% of total cost to the trainee if desired as an investment in his own future , this loan to be repaid as a fixed percent of future gross income for 30 years. The trainee has already invested $10,000 in foregone income.

(6) State or local governments could contribute to the trainee and reduce his need of #5 as

inducements to enhance local manpower needs

(7) These percentages and the means of handling instructional costs are open to discussion.

Such a program should be politically feasible and more important, equitable.

TABLE I

Allocation of Benefits and Costs of Biomedical Research and Clinical Training Programs*

Total Cost: 12,000 Stipend
4,000 instruction cost
10,000 foregone income (physician)
26,000

Beneficiary	% Benefit	% Total cost		Stipend makeup	
Society	20	$5,200		$5,200	
	(25)	(6,500)		(6,500)	from institution
Service	20	$5,200	(-4,000)	1,200	
teaching and patient care	(25)	(6,500)		(2,500)	
Self	60	$15,600	(-10,000)	5,600	
	(50)	(13,000)		(3,000)	from trainee
		$26,000		$12,000	

*Figures in parentheses show a second model based on different benefit allocation.

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(2) HEW Statement in Support of Fiscal '74 Budget.

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Bowsher, P. DHEW Secretary Richardson's Mega-proposal. AAMC, January 22, 1973.

(4) Fein, R. and Weber, G. Financing Medical Education. McGraw Hill, 1971.

(5) Millis, J. A Rational Public Policy for Medical. Education and Its Financing National Fund for Medical Education, N.Y., 1971.

(6) Educational Opportunity Bank, A Report of the Panel on Educational Innovation to the U.S. Commissioner of Education and the Director of NSF. U.S. Government Printing Office. August, 1967.

(7) Shell, K. et al. National Tx Journal, XXI:2-45, 1964; XXIII 214-20, 1970.

Harvard Medical Alumni Bulletin 43:2-4, 1969.

(8) Nelson, B, et al. Jr. Med. Educ. 47:603-611, 1972.

(9) Higher Education and the Nation's Health. McGraw-Hill, N.Y. 1970.

V. Information Items:

1. Biomedical Research Committee - Dr. Estabrook

The Committee on Biomedical Research and Research Training has met twice since its activation, January 1, 1973. The Committee has decided to approach the question of the cost of the biomedical research contribution to medical education by developing data as to the view of the students and the faculty regarding the importance of biomedical research in the education of a physician. The first questionnaire will attempt to develop an understanding of the view of the medical student regarding the contribution of biomedical research to his education. The second questionnaire will be distributed to faculty and will attempt to ascertain the view of the faculty regarding the relationship between biomedical research and medical education. A third aspect of this study may involve questions being distributed to the cohort of the medical student class of 1960, who are participating in the AAMC longitudinal study.

The Committee is also beginning to concern itself with the role of the AAMC in long-term development of biomedical research policy. In this regard, the Committee has endorsed the concept of the National Diabetes Act of 1973 and requests that staff of the Association work with voluntary non-profit organizations which support these types of legislation to ensure that adequate provision is made for investigator-initiated project research.

3. Advisory Committee on AAMC Educational Resources Program.

The Advisory Committee for the multimedia accession and indexing project in conjunction with the National Library of Medicine has had one meeting. Strategies and plans for announcing the program to the constituency and the accession of multimedia materials were developed at that meeting.

5. Primary Care

Bob Kalinowski of the Division of Health Services has acquired the assistance of Dr. Thomas Piemme of George Washington University on a part-time basis to develop a proposal for a model primary care educational and health services program. This work is in its beginning stages. A brief report will be made.

APPENDIX* (To Functions and Structure of a Medical School)

Programs in the Basic Medical Sciences

I. Introduction

Since undergraduate medical education is but a part of the continuum of the life long education of the physician, a program in the basic medical sciences merits special comment. The continuum of medical education consists of a series of sequential learning experiences available to the student of medicine at the same or different institutions. Premedical education leading to the baccalaureate degree is the institutional responsibility of the college or undergraduate division of a university. Undergraduate medical education, including both the basic medical sciences and clinical science, with an increasing integration of the components leading to the doctor of medicine degree is the responsibility of a medical school. Graduate medical education, following the granting of the doctor of medicine degree, by means of residency programs prepares the physician for practice and is a responsibility of the medical school or teaching hospital. Completing the continuum, continuing education affords the physician varied learning experiences appropriate for his clinical responsibility and is provided by professional associations, medical schools, and teaching hospitals.

In the past, the several program components of this continuum were offered as discrete and isolated segments. Now, efforts should continue to achieve greater integration of the several elements despite the possible diversity of their sponsoring organizations and their geographic locations. A recognition of this continuum by institutions having a responsibility for undergraduate medical education is of special significance because integration is particularly necessary in the conduct of undergraduate medical education. The study of the basic medical sciences and the study of clinical science cannot be separated. A single curricular pattern for the attainment of this integration cannot be prescribed.

II. Definition and Mission

Programs in the basic medical sciences are of less than 32 months duration, do not culminate with the award of the M.D. degree, provide the initial part of undergraduate medical education, and must be affiliated with an approved medical school. Although primarily concerned with the sciences which are basic to the study of medicine, these programs must include the opportunity for the simultaneous study of clinical medicine. This appendix modifies the preceding statement so that it is applicable to the evaluation for accreditation of programs in the basic medical sciences.

*Adopted by the LCME, January 10, 1973.
Adopted by the House of Delegates of the American Medical Association on _____, and the Assembly of the Association of American Medical Colleges on _____.

If undergraduate medical education is divided between a program in the basic medical sciences and the program of a degree-granting institution, it is ultimately the responsibility of the degree-granting institution to assure the continuity and integration of the curriculum.

A program in the basic medical sciences has the same inherent responsibilities as described in Section II of the preceding statement. The extent of these responsibilities, especially as they involve responsibility for the care of patients, may be abridged providing they are appropriate for the attainment of stated and acceptable objectives of the commitment to undergraduate medical education.

III. Educational Programs

The educational program in the basic medical sciences assumes that the students will have completed the premedical program. It offers them an education which will prepare them adequately for entrance with advanced standing into an approved medical school.

It is of utmost importance that instruction not be conducted exclusively in the basic sciences without any experience in clinical medicine. Instruction in clinical medicine is necessary to facilitate the correlation of the scientific and clinical aspects of medical knowledge as well as to reinforce the students' motivation for medicine and provide the opportunity to acquire necessary attitudes, skills and techniques and to begin the acquisition of a professional identity. The experience requires careful planning with participation by qualified teachers of clinical medicine who are competent in both the basic and the clinical sciences.

This usually requires that there be a program of graduate medical education at an affiliated hospital where faculty and house staff can serve as role models for the student.

IV. Administration and Governance

Programs in the basic medical sciences must be conducted by a college or university. Whether the program does or does not constitute a separate college or school, there should be a recognizable organization of faculty including a committee structure similar to the organization of a degree-granting medical school.

Administrative responsibility for the program must rest with a dean or director who has adequate authority with respect to the necessary resources such as faculty, budget, space, library, learning resources, and research facilities.

The governance of the program in basic medical sciences should include substantive representation from the affiliated medical school in order to assure coordination of the program with the objectives of that institution, particularly in the area of admissions, curriculum, student evaluation, promotion and transfer and faculty recruitment and promotion.

Provision for this representation must be by means of a formal affiliation which acknowledges the responsibility of the medical school which will award the M.D. degree for the adequacy of the continuum of undergraduate medical education. It is recognized that several currently approved programs do not have such an affiliation. For these programs this requirement is deferred, if there is evidence that development of such an affiliation is in progress.

V. Faculty

The faculty must consist of a sufficient number of skilled teachers and investigators from the biological, behavioral, and clinical sciences to achieve the objectives of the particular program. The specific fields to be represented will be determined in part by the prerequisites set by the affiliated clinical program and do not have to be structured in any set pattern of departmental or divisional organization. A significant portion of faculty effort should be devoted to the facilitation of learning by those who enroll as students. In addition to the educational efforts of the faculty scholarly productivity should be encouraged. Depending on the discipline involved, the basic science faculty in the program will find it important to retain strong ties with their counterparts in the arts and sciences programs. Thus, the program in the basic medical sciences will draw academic sustenance from the more basic as well as the more applied portions of their disciplines. It will depend on the skills of the academic and administrative leaders of the program to provide conditions which permit this integration.

Nominations for faculty appointment should involve participation of faculty, the dean or director, and the M.D. degree-granting institution, the role of each customarily varying somewhat with the rank of the appointee and the degree to which administrative responsibilities may be involved.

Physicians practicing in the community may contribute significantly to the educational program but do not obviate the need for full time physician-teachers on the faculty.

VI. Students

The affiliation between the institution responsible for a program in the basic medical sciences and the medical school awarding the M.D. degree should assure the transfer to the medical school of the student whose progress in the program is satisfactory.

There must be a well defined mechanism for student selection and formal acceptance into the program, evaluation of student performance, and determination of qualification for transfer into a clinical program offering the M.D. degree. At a specific point in the program the student must be identified and formally registered as a medical student.

VII. Finances

Although the amount of financial support necessary for a program in the basic medical sciences will be less than the amount required for a complete program of undergraduate medical education, the qualitative requirements are the same.

VIII. Facilities

The qualitative requirements for facilities are described in the preceding statement; the quantitative requirements will be determined by the extent of the program in the basic medical sciences.

IX. Accreditation

Section IX of the preceding statement is applicable to programs in the basic medical sciences.

The Liaison Committee has categorized the types of basic medical science programs that it will consider for accreditation as follows:

1) Existing two-year programs accredited or provisionally accredited,

2) New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium, and

3) New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case, the program will be accredited as a component of the M.D. degree-granting institution or institutions.

It is the policy of the Liaison Committee to discourage the establishment of programs in the basic medical sciences for medical students that do not have a clearly defined pathway leading to the M.D. degree. Recognizing the need for mobilizing additional university resources for the benefit of medical education, the Committee may approve a basic medical science program through the degree-granting school with which it is affiliated. In this case the program will be surveyed initially upon request and subsequently as part of the regular review process of the affiliated medical school.

An institution planning a program should seek detailed information about accreditation early in the planning process.

International Consortium for the Advancement of Female Health

Background

AID, through its Bureau of Population and Humanitarian Assistance, is proposing to develop a program aimed at worldwide improvement of female health as an effective mechanism for raising the standard of health of the family and particularly, the child. The proposed project consists of the following three component programs:

1. To develop an international system for continuing education of Ob-Gyn leaders in medical schools and in practice in the area of reproductive biology, demography, maternal and child health, and fertility control;

2. To initiate a network of female health clinics by the trained specialists;

3. To establish a supply system for equipment and materials used in these clinics.

In order to develop a program of continuing education which can reach Ob-Gyn faculties at their request in countries accessible to AID and which may make best application of modern educational technology, it is proposed to establish an international consortium which will assume responsibility for all these phases of the project.

Specific Project

Since it is widely recognized that medical school faculties are an important and frequently the only resource for leadership and innovation, the participation of Ob-Gyn faculties, medical schools and their national and international associations or federations is important. Thus, AID is turning to AAMC for assistance in establishing the international consortium for the project. Specifically, AAMC has been requested to assume the responsibility for the initiation and establishment of the consortium which then will receive five years of guaranteed support for the implementation of the project. The contract with AAMC will be limited to 12-18 months depending on the progress in the initial negotiations.

Recommendation

Since AAMC serves as a consultant to AID in the area of international health and since the purpose of the contract is limited to initiating the engagement of health professions education institutions in the project effort, it is recommended that the Executive Council authorize negotiation of a contract.

WHO Study on International Migration of Health Manpower

Background

International migration of health manpower, particularly of physicians and nurses, has assumed major proportions and has important implications for donor and recipient countries. Background data on the movement of these professionals and their motivating factors, and the consequences of their movement for health care in affected countries are not available. In order to provide basic information necessary for an assessment of the situation in different countries and for gaining an understanding of its dynamisms, the World Health Assembly of 1972 requested the director-general of WHO to undertake a comprehensive study. Plans and instruments for this study have been developed in Geneva under the direction of Dr. Alfonso Mejia.

Objectives

The study has the following objectives:

1. To determine dimensions and patterns of migration of physicians and nurses.

2. To identify characteristics, motivation, satisfaction and dissatisfaction of those who migrate.

3. To determine economic and non-economic factors which cause physicians and nurses to migrate.

4. To identify in the affected countries the economic and non-economic effects of migration.

5. To postulate alternative strategies for monitoring and intervening, if necessary, in the process of migration.

Methods

The study will assemble existing information and conduct five surveys using questionnaires. The content of the five surveys is:

1. Health services subsystem using random sampling of health care institutions.

2. Health manpower subsystem using random sampling of physicians and nurses.

3. Health professional education subsystem.

4. General survey of migration.

5. Subject survey of migrant physicians and nurses in the format of selected case studies.

In each country selected for participation a sponsoring agency will be identified and a project director and advisory committee will be appointed.

It is expected that the study will require approximately two years for completion.

Countries

Out of the proposed countries between 15 and 25 will be selected for participation. Presently, the following countries are proposed:

Donors

Africa	Cameroon, Ghana, Kenya, Madagascar, Senegal, Tanzania
The Americas	Argentina, Colombia, Jamaica, Mexico, Trinidad, Tobago
Eastern Mediterranean	Iran, Lebanon, Pakistan, Israel
Europe	Greece, Italy, Portugal, Spain, Turkey
Southeast Asia	India, Republic of Sri Lanka, Thailand
Western Pacific	Malaysia, New Zealand, The Philippines Singapore, South Korea, South Pacific Islands

Recipients

Federal Republic of Germany, France, Sweden, U.S.

Donors and Recipients

Australia, Canada, United Kingdom

Cost

Assuming 20 participating countries, the total cost is estimated to amount to U.S. $650,000. For each additional country, approximately $20,000 must be added.

Recommendation

In view of the general importance of the issue of the FMG in the U.S. and of the expectation that this study will provide valuable data, it is recommended that AAMC endorse the proposed study by WHO and offer its participation without incurring any financial responsibilities unless funds can be obtained by outside sources.

PROPOSED MEDICARE CHANGES

U. S. DEPARTMENT OF

HEALTH, EDUCATION, AND WELFARE

Office of the Secretary
Washington, D. C. 20201

FOR RELEASE AT 12 NOON (EST) MONDAY, JANUARY 29, 1973

CAUTION: The attached document is based on the President's budget scheduled for delivery to the Congress on Monday, January 29, 1973, and is strictly embargoed until noon of that day.

It must be held in strict confidence. No portion, synopsis, or intimation of its contents may be published until release time, nor may any of its contents be paraphrased, alluded to, or hinted at in stories or commentary while the embargo is in effect.

The same caution applies to newspapers, radio and television commentators and news broadcasters, both in the United States and abroad.

PLEASE USE EXTREME CARE TO AVOID PREMATURE PUBLICATION OR ANNOUNCEMENT.

C O R R E C T I O N

PAGES 81-84 ARE INCORRECTLY NUMBERED AND PLACED. THEY SHOULD BE INSERTED BETWEEN PAGES 72 AND 73.

Medicare

A number of significant administrative and legislative changes are included in the Medicare budget estimates for FY 1974. The Social Security Amendments of 1972 provide for a substantial broadening of the program by extending Medicare coverage to social security disability beneficiaries who have been entitled to disability benefits for two years or more. This new coverage, effective July 1, 1973, is expected to add 1.7 million disabled persons to the program and increase FY 1974 benefit outlays by $1.7 billion.

The Amendments also contain a number of important cost and quality control provisions which are reflected in the estimates. These include limits on provider costs recognized as reasonable, provisions establishing reimbursement procedures for health maintenance organizations, limits on reimbursements for capital expenditures not approved by State health planning agencies, and, perhaps most important for the future, the establishment of a nationwide network of Professional Standards Review Organizations (PSRO). These are organizations through which practicing physicians will assume responsibility for reviewing, on a comprehensive and integrated basis, the necessity for and quality of institutional and outpatient services under Medicare and Medicaid. Funds totalling $9 million in FY 1973 and $34 million in FY 1974 are included in Medicare, Medicaid, and Departmental Management to finance the start-up of PSRO's throughout the country.

In FY 1973, an administrative change is being made to the present method of reimbursing providers in the hospital insurance program. At the beginning of the Medicare program in 1966, there was considerable concern that substantial numbers of institutional health care providers would decline to participate in the program until a fully satisfactory system of processing and paying Medicare claims was established and proved. To provide assurance against the possibility of long delays in routine reimbursements, a mechanism termed "current financing" was established. This device, in effect, provided special payments to providers concurrent with the time services were rendered. Now that the routine claims process has been established and the original concern over large backlogs eliminated, this particular procedure is no longer as important. Its termination will allow the recovery of approximately $300 million in funds advanced under its provisions. If delays in payment occur in unusual cases, an accelerated payments procedure will still be available to providers if the need can be currently demonstrated.

New proposals to help control rising medical costs are also included in the Medicare budget. While the Phase III price controls on medical costs, coupled with an increased utilization review and pre-admission certification effort, will exercise a restraining influence on Medicare cost increases, we are also seeking to encourage greater cost consciousness and cost awareness on the part of the medical care consumer in order to minimize over-utilization of medical services. To this end, legislation will be proposed to become effective January 1, 1974, increasing cost sharing in both the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) components of the Medicare program. Were it not for the combined effect of these administrative actions and legislative proposals, the FY 1974 Medicare budget would be $893 million higher. Savings from the legislative proposals will be

marginally offset by a $44 million increase in Medicaid costs. The HI program currently contains an initial deductible amount the beneficiary must pay which is equal to the national average cost of one day's stay in a hospital (currently $72). The beneficiary pays nothing further until the 61st through 90th days of hospital stay, during which time he is charged a daily amount equal to one-fourth of the initial deductible. If the beneficiary needs more than 90 days of hospital care in a benefit period, he has a lifetime reserve of 60 additional days. For each lifetime reserve day used, he pays one-half of the initial deductible. Thus, the current system provides for major cost sharing only at the end of a long hospital stay--when the beneficiary is least able to afford it--while doing little to counteract over--utilization at an earlier stage of hospitalization when it is most likely to occur. Moreover, the amount the beneficiary pays bears no relationship to actual costs incurred and services rendered in the course of his hospitalization.

Legislation to be proposed would replace the current HI cost-sharing system with a new system under which the beneficiary would pay daily amounts equal to ten percent of actual hospital, extended care facility, or home health agency charges for that day, after having met an initial hospital deductible amount equal to one day's actual room and board charges. Thus, the proposed system has the advantages of tying cost-sharing to actual charges and services used, instituting it at a point where it is likely to discourage over-utilization, and eliminating high cost-sharing at the end of a long hospital stay. It is intended to establish a cost awareness on the part of the medical care consumer which, besides its effect on over-utilization, should inhibit hospital price increases.

Two legislative changes also are proposed in the SMI program. The first increases the initial deductible to $85 from its present $60, while the second increases the percentage amount of subsequent bills which the beneficiary pays from 20 to 25 percent. Since the SMI program came into being in 1966, the deductible has increased only 20 percent, despite an increase in physicians' fees of close to 50 percent and an increase in cash benefits paid to Medicare beneficiaries of more than 70 percent. The proposed deductible has been increased by the same percentage that Social Security cash benefits have increased since the inception of the SMI program--and would increase in the future as cash benefits are raised. It would, in effect, keep pace with the beneficiary's ability to pay.

In FY 1974 about 23.1 million persons will be covered under the provisions of the Hospital Insurance program and 22.5 million under SMI. Medicare benefit outlays are expected to be $11.9 billion under current law, an increase of $2.8 billion over FY 1973. Including proposed legislation, FY 1974 benefit outlays are expected to be $11.4 billion. Total Medicare outlays are estimated at $12.1 billion.

might be interested in this

THE JOHNS HOPKINS UNIVERSITY

SCHOOL OF MEDICINE

DEPARTMENT OF PEDIATRICS
ROBERT E. COOKE, M.D.
Director

Please address reply care of
THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MARYLAND 21205

TO CHAIRMEN OF DEPARTMENTS OF PEDIATRICS

At the business meeting on February 15, 16, and 17, 1973, you as a Department Chairman are going to have an opportunity to vote concerning withdrawal of your group from the Council of Academic Societies and the American Association of Medical Colleges. This open letter is written to provide you with important information which, hopefully, will prompt you to vote for continuing membership. Unfortunately, a commitment made prior to my appointment as Acting Chairman here at Johns Hopkins may preclude my being with you to personally express my views, and, therefore, they are summarized in this letter.

My concerns about the CAS and the AAMC were similar a year ago to those which the Association of Pediatric Chairmen now have. A number of significant events within the CAS have prompted me to now believe that the CAS and the AAMC constructively speak for all of us in academic medicine and can do a job which we need to have done, and for which there is no other mechanism to accomplish the task. The developments, in chronological order, that have provided me with this belief are as follows: 20 months ago in San Francisco Bob Greenberg, representing the SPR, Mike Ball, President-elect of the AFCR, Jack Oppenheimer and myself, Co-Chairmen of the Public Affairs Committee of the Endocrine Society, Claude Migeon, as an interested party, and Hugh Fudenberg, representing the Public Affairs Committee of the Society for Clinical Investigation, met as a non-official group to explore methods that would enhance legislation favorable to research and training. This meeting was prompted by the concerns of Mike Ball, Jack Oppenheimer, and myself. Our concerns developed while we were working as members of the Public Affairs Committee of the Endocrine Society and while we were ascertaining if a lobbying organization could be established in Washington which could promote legislation favorable to research and training. This group considered various mechanisms, and, in general, agreed that the Council of Academic Societies probably could not supply the initiative and drive to get the job done. Those of you who attended the business meeting of the SPR in 1971 will recall that I made a resolution and motion which are attached (#1). The purpose of this motion was to make it possible for the SPR to join the organization which we hoped to establish without waiting until another business meeting was held. The motion was passed.

Subsequently, one month later, I presented before the Executive Council of the Endocrine Society a proposal which was accepted, but we were advised to pursue further the possibility of working with the CAS and AAMC because of the expense involved in establishing a separate organization, and because it would take a great deal more time to organize a completely new structure than to utilize one already established. Mike Ball, Claude Migeon, and I actively pursued the feasibility of accomplishing the job which we wanted done with the CAS. Mike and I appeared before the Administrative Board of the CAS in the early fall with a proposal (#2). The Administrative Board reacted with little favor on our proposal. However, the Welt committee had recommended to the CAS that a specific position be set up concerned with biomedical research and training. Since the Board of the CAS did not respond favorably to us, even though Gus Swanson was totally in favor of our concepts, Mike Ball and I visited with Gus on several occasions. Out of these discussions came the employment of Mike Ball himself for the position of dealing with the CAS regarding biomedical research. Because Mike felt that this was such an essential job in assisting all investigators in the country, he took a leave of absence from Georgetown to join the CAS. Mike has significantly extended the activities of the CAS in influencing legislative proposals regarding research and training. Since joining the CAS he has been very effective in talking to legislators, including Paul Rogers. In addition, he and John Cooper, for the first time, were able to attain an audition for the medical profession at the OMB where President Nixon has bottled up appropriated monies. A report of the Public Affairs Committee of the Endocrine Society which I gave in June, 1972, and which gives further insight into these developments is attached (#3).

The CAS will be further assisted in achieving our goals by Dave Challoner, who is active both in the Public Affairs Committees of the Endocrine Society and the AFCR, and myself. We both were elected to the Administrative Board just two weeks ago. Ron Estabrook from Texas is the new Chairman of the Administrative Board, and along with Mike, Dave, and myself, is an activist. Bill Weil also sits on the Board. Gus Swanson and John Cooper are totally in favor of our activities and are supporting them fully. Consequently, my impression of the capabilities and interests of the CAS and AAMC has completely reversed in the past 12 months.

It is my belief that each Association of Department Chairmen and the scientific groups such as the Endocrine Society must support the CAS and AAMC. This organization is no longer a Council of Deans, although that is one of the three arms of the organization. Our Council of Academic Societies, which is a second arm, should promote what is beneficial to every department, whether it be medicine, surgery, or pediatrics. Our pediatric departments will consequently benefit. It is unrealistic to believe that the Council of Academic Societies can frequently become involved in matters which would directly benefit any single one of the Associations of Department Chairmen. However, their activities indirectly benefit all the Associations of Department Chairmen.

I join Bill Weil and Ralph Wedgwood, both of whom have had the opportunity to see the maturation of the CAS this past year, in urging this group not to withdraw from the Council of Academic Societies at this time. Although the dues increase could be a deterrent to continuing membership, this represents only a token of the cost of the activities of the Council of Academic Societies, and to withdraw because of an assessment of a few dollars per chairman could be an imprudent act. There is not one of us who would not write a check for $50.00 to support an organization that could favorably influence the activities in Washington which are essential to our livelihood. Therefore, why should we hesitate to contribute a few dollars for the same purpose by contributing through the Association of Department Chairmen?

Again, I urge all of you to reconsider the recommendation of the Executive Council and defer action concerning withdrawal of the Association of Department Chairmen of Pediatrics until at least next year.

Respectfully submitted,

Robert M. Blizzard, M.D.
Acting Chairman
Department of Pediatrics

RMB:cv

Attachments

Status Report on

MCAT DEVELOPMENT ACTIVITY

A provisional name has been designated - Medical College Admission Assessment Program (MCAAP). The key word is "assessment". This word was deliberately chosen to suggest a broader range of data collection beyond that ordinarily implied by a testing format, e.g. biographical information. The purpose of the program is to update and expand the MCAT and increase the amount of useful information available during the admissions process.

A systematic effort is suggested for obtaining constituent input and consensus on instrument construction and research and development activity. This effort began in a serious way about a year ago when your response to a "Proposal for a Program of Pre-enrollment Assessment" was requested. Some concrete topics for discussion were identified which hopefully will provide a departure point for discussion at the spring meetings of the appropriate councils and subcouncilar units of the Association. Jim Angel, program director of MCAAP, will be working with the various regional chairmen to identify a regional representative who will facilitate discussions within regions where possible, organize the regional input, and supply continuity in later discussions.

Following regional meetings, the current plan is to organize regional conferences in June sponsored by MCAAP and devoted exclusively to discussion of plans and priorities for program development. Participation would be open to all interested representatives from all constituent bodies of the AAMC within that region. The various regional representatives previously identified would play a major role in transmitting the concerns of their organization at these discussions and in representing a synthesis of these concerns at a task force to take place in July. Invitation to the task force sessions would include the regional representatives and a few at-large members. The primary objective of the task force sessions would be consensus on immediate plans and priorities for test construction activities and research effort.

Concurrently, a contractor will be identified to interact with the constituency at these various opportunities and draw up a set of specifications which will also include its independent recommendations.

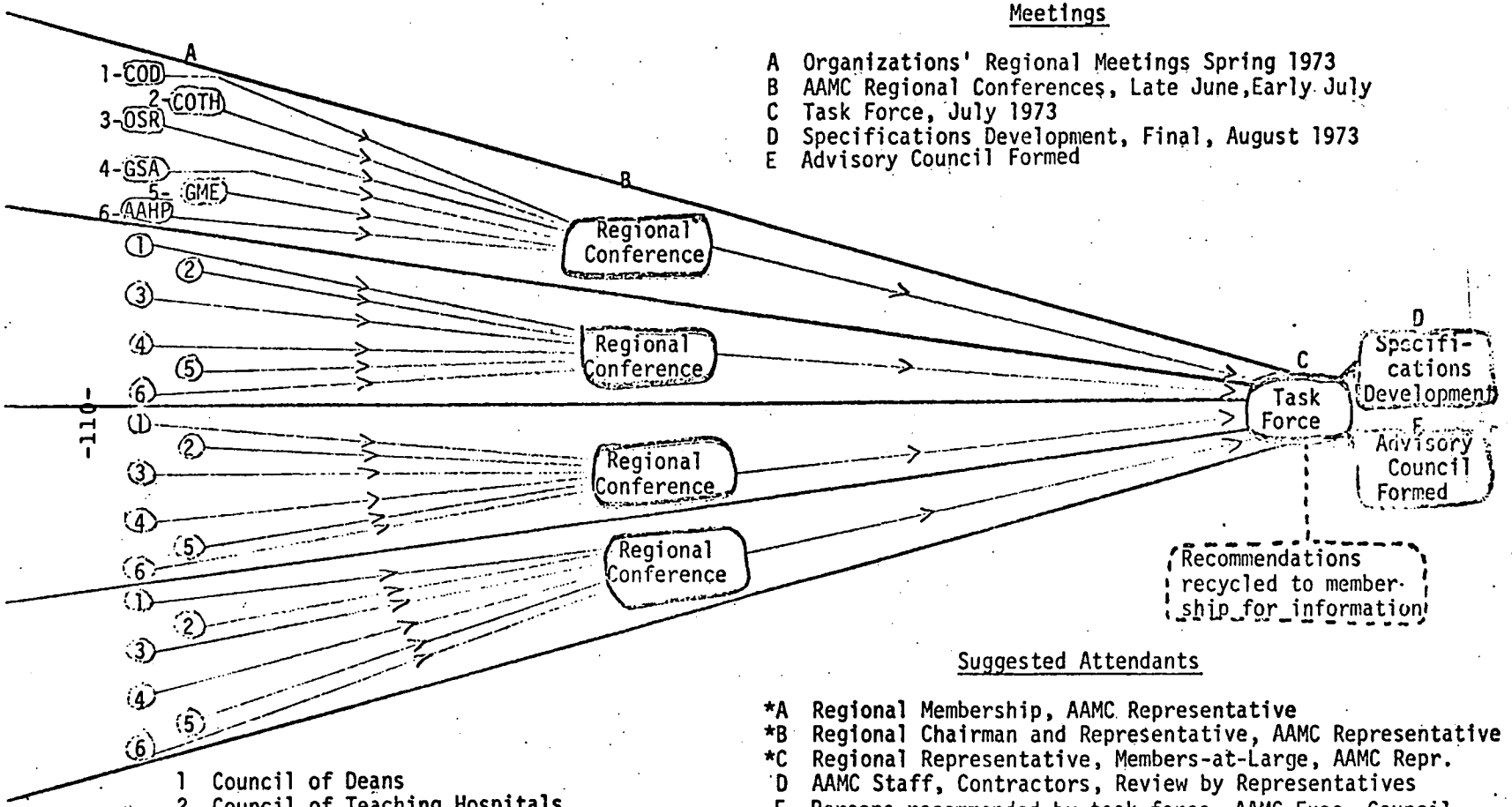
Finally, an advisory body will be identified from those contributing to the ultimate consensus in order to provide continuing guidance to the developing program.

EXHIBIT I. Medical College Admissions Assessment Program, Division of Educational Measurement and Research

AAMC
2/73

DIAGRAM OF COUNCIL/GROUP AND TASK FORCE INVOLVEMENT[1]

MCAT Revision Planning



Meetings

A Organizations' Regional Meetings Spring 1973
B AAMC Regional Conferences, Late June, Early July
C Task Force, July 1973
D Specifications Development, Final, August 1973
E Advisory Council Formed

Suggested Attendants

*A Regional Membership, AAMC Representative
*B Regional Chairman and Representative, AAMC Representative
*C Regional Representative, Members-at-Large, AAMC Repr.
D AAMC Staff, Contractors, Review by Representatives
E Persons recommended by task force, AAMC Exec. Council
*Some meetings possibly attended by contractor representative

1 Plans being formulated for CAS participation also.

1 Council of Deans
2 Council of Teaching Hospitals
3 Organization of Student Representatives
4 Group on Student Affairs
5 Group on Medical Education
6 Association of Advisors to the Health Professions

Not named is Council of Academic Societies, which may have involvement of some dimension.

1CAAP/JLA
:/7/73

[Rogers Bill]

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

March 16, 1973

TO: Committee on Biomedical Research and Research Training

FROM: Michael F. Ball, M.D.

SUBJECT: NEXT COMMITTEE MEETING

The next meeting of our Committee will be held Tuesday, March 27, 1973, in Room 827 of One Dupont Circle, beginning at 9:30 a.m. We anticipate that the meeting will be completed by 4:00 p.m.

Dr. Charles Sprague, Chairman of the AAMC and Chairman of the Committee on Financing of Medical Education, will meet with the Committee to discuss the cost of the contributions of biomedical research to medical education and will apprise the Committee of the progress of the Committee's deliberations.

We would also plan to present a preliminary report on the survey of the institutional impact of the changing patterns in federal funding for FY 73 and 74 on the institutions. I would hope that the Committee could come to a decision as to its role in this immediate problem.

Enclosed please find a copy of a bill entitled "The National Health Research Fellowship and Traineeship Act of 1973" which was introduced in the House of Representatives on Wednesday, March 14, 1973 by Congressman Rogers. Testimony will be taken on Tuesday, March 20, Thursday, March 22 and Friday, March 23. We will plan to advise you on developments in this area also.

enclosure

MFB:sd

93d Congress
1st Session

Mr. Rogers

A B I L L

To amend the Public Health Service Act to establish a national program of health research fellowships and traineeships to assure the continued excellence of biomedical research in the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Short Title

Section 1. This Act may be cited as the "National Health Research Fellowship and Traineeship Act of 1973".

Findings and Declaration of Purpose

Sec. 2. (a) Congress finds and declares that--

(1) the success and continued viability of the Federal health research effort depends on the availability of excellent scientists and a network of institutions of excellence capable of producing superior research personnel;

(2) direct support of the training of biomedical scientists for careers in research is an appropriate and necessary role for the Federal Government; and

(3) graduate training grant and research fellowship programs should be the key elements in the training programs of the National Institutes of Health and the National Institute of Mental Health (and their respective research institutes).

(b) It is the purpose of this Act to increase the capability of the National Institutes of Health and the National Institute of Mental Health (and their respective research institutes) to carry out their statutory responsibility of maintaining a superior national program of biomedical research into the basic biological processes and mechanisms involved in the physical and mental diseases and impairments of man.

Health Research Fellowships and Traineeships

Sec. 3. (a) Part F of title III of the Public Health Service Act is amended by adding after section 433 the following new section:

"Health Research Fellowships and Traineeships

"Sec. 434. (a) The Secretary, in accordance with regulations, shall--

"(1) establish and maintain research fellowships in the National Institutes of Health and the National Institute of Mental Health (and their respective research institutes) with such stipends and allowances (including travel and subsistence expenses and dependency allowances) as he may deem necessary to train research workers and procure the assistance of research fellows from the United States and abroad, and, in addition, provide for research fellowships through grants to public and other nonprofit institutions; and

"(2) provide training and instruction, and establish and maintain traineeships, in such institutes in matters relating to the diagnosis, prevention, and treatment of the disease or diseases to which the activities of such institutes are directed with such stipends and allowances (including travel and subsistence expenses and dependency allowances) for trainees as he may deem necessary, and,

in addition, provide for such training, instruction, and traineeships through grants to public and other nonprofit institutions.

"(b) Assistance provided under subsection (a) shall be for the training of persons intending to enter research or teaching. No individual may receive assistance under subsection (a) for more than three years.

"(c)(1) Any assistance provided any individual under subsection (a) shall be provided on the condition that such individual will, in accordance with paragraph (2), engage in research or teaching for a twenty-four-month period for each full academic year with respect to which he received such assistance.

"(2) The requirement of paragraph (1) shall be complied with by any individual to whom it applies within such reasonable period of time, after the completion of such individual's training, as the Secretary shall by regulation prescribe. The Secretary shall by regulation prescribe (A) the type of research and teaching which an individual may engage in to comply with such requirement, and (B) such other requirements respecting such research and training as he deems necessary.

"(3) If any individual to whom the requirement of paragraph (1) is applicable fails, within the period prescribed under paragraph (2), to comply with such requirement for the full number of months with respect to which such requirement is applicable, the United States shall be entitled to recover from such individual an amount equal to the product of--

"(A) the aggregate of (i) the amount of assistance provided to such individual under this section, and (ii) the sums of the interest which would be payable on such assistance if, at the time such assistance was provided, such assistance were a loan bearing interest at a rate fixed by the Secretary of the Treasury, after taking into consideration private consumer rates of interest prevailing at the time such assistance was provided and if the interest on each such assistance had been compounded annually, and

"(B) a fraction the numerator of which is the number obtained by subtracting from the number of months to which such condition is applicable a number equal to one-half of the number of months with respect to which

compliance by such individual with such requirement was made, and the denominator of which is a number equal to the number of months with respect to which such requirement is applicable.

Any amount which the United States is entitled to recover under this paragraph shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States. Until any amount due the United States under this paragraph on account of any assistance provided under this section is paid, there shall accrue to the United States interest on such amount at the same rate as that fixed by the Secretary of the Treasury pursuant to clause (A) with respect to the assistance on account of which such amount is due the United States.

"(4)(A) Any obligation of any individual to comply with this subsection shall be cancelled upon the death of such individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any such obligation applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

"(d) The review and award of fellowships under this section and the number of persons receiving training and instruction and holding traineeships under this section shall be subject to the review and approval of the appropriate advisory councils to the several institutes and their respective divisions and bureaus.

"(e)(1) There are authorized to be appropriated to carry out subsection (a)(1), $50,000,000 for the fiscal year ending June 30, 1974; $52,500,000 for the fiscal year ending June 30, 1975; and $55,000,000 for the fiscal year ending June 30, 1976. There are authorized to be appropriated to carry out subsection (a)(2), $154,000,000 for the fiscal year ending June 30, 1974; $162,000,000 for the fiscal year ending June 30, 1975; and $170,000,000 for the fiscal year ending June 30, 1976.

"(2) Funds duly appropriated by law to carry out this section shall be obligated and expended in the manner provided by law for their intended purposes; and no part of any such funds shall be impounded after the date of the enactment of this section, whether by withholding or delaying their obligation or expenditures, by terminating the projects,

programs, or activities for which they were appropriated, or by taking any other type of executive action which effectively precludes their obligation or expenditure."

(b) Section 433(a) of such Act is amended by striking out the last two sentences.

[AAMC Institu. Survey]

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Suite 200
One Dupont Circle, N.W.
Washington, D. C. 20036

By March 9, 1973, or as soon thereafter as possible, please return one copy of this page, one copy of the narrative statement, and one copy of the questionnaire forms (all pages) to:

Division of Operational Studies
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Suite 200
One Dupont Circle, N.W.
Washington, D. C. 20036

Please call Mr. Joseph Rosenthal, (202) 466-5129, should you have any questions concerning the questionnaire.

Please furnish the name and telephone number of the person at your school whom we may contact concerning your response.

_____, _____
Name Title

_____
Area code - telephone number

QUESTIONNAIRE

Purpose of the Questionnaire

The President's Budget recommends a series of changes in the funding of programs supporting the activities of the Nation's academic medical centers.

An assessment of the effect of these changes will be prepared by the Association, but in order to do so quantitative information on the impact of these recommendations on the operations and finances of your institution will be necessary. This information will be combined with the data for all other medical schools, so that an aggregate picture will emerge.

The difficulty in providing information which will present an accurate summary of the effects of these proposed changes on the complex organizational and programmatic structure of your institution is recognized. Nevertheless, your cooperation in this matter is essential, so that the Association may be able to present the overall impact of these funding changes in as effective a manner as possible.

The impact of budget cutbacks is more obvious where the cut is so deep that the levels of Federal support for fiscal year 1973 and fiscal year 1974 will be substantially below actual receipts in fiscal year 1972. Many schools, however, may have had very reasonable expectations of program increases, and the impact will be more severe where reliance has been placed on such expectation. The original estimate column on the questionnaire forms, then, is the amount used in your planning for fiscal year 1973 prior to announcement of the recent Federal reductions, and it is against this yardstick of expectation that the impact is to be measured.

To assist you in providing the requested information, you will receive, under separate cover, a computer print-out, prepared at our request by the National Institutes of Health, which will cover the fiscal year 1972 awards,

and the awards made so far in fiscal year 1973, showing the amounts originally committed for successive years, for the following program areas:

Regular research grants Fellowships Career awards Research and applied training grants	By Department of your institution
Program project and center grants General research support grants Other general support Construction Student assistance	For your institution

For each department and for each institutional grant, awards will be shown by each of the components of the National Institutes of Health and of the Health Services and Mental Health Administration.

The Questionnaire - Instructions

The general narrative statement for which space has been provided at the beginning of the questionnaire is intended to obtain as specific descriptive information as possible at this time on the effects of these changes on school programs, the only way in which much of the impact can really be understood. Even here, however, illustrative quantitative statements would be very helpful. Please use as many additional pages as are necessary.

Guidelines for Narrative Statement

On the basis of the analysis of the fiscal situation for your institution, as reported in detail in the questionnaire, what is your summary assessment of the overall effect of these probable changes in funding on the major program areas of your medical school, considering such related factors as the announced changes in the medical service and research programs of the Veterans Administration. This statement should cover the following areas:

Undergraduate medical education program

Will the estimated levels of financial resources support the enrollment of first-year students you had originally planned? What will be the effect on the enrollment of minority and low-income students? Will the reduction in funds for the scholarship program administered by the Bureau of Health Manpower Education significantly affect your plans for the enrollment of these students or other medical students? Will your plans for curriculum improvement, and enrichment have to be modified?

Graduate education programs

How will these programs be affected in terms of the numbers of students, in terms of the training provided? What will be the effect on your graduate programs in basic science - clinical fields, etc?

Other Education Programs

Will your continuing medical education program be limited because of the phasing out of the regional medical program? What other educational programs will be affected and in what manner?

Research Programs

Will your institution be able to support the research activities of the promising new investigator, with the proposed reduction in general research support grants? Will your institution be in a position to make up for the loss in faculty salary support previously provided through research grants and contracts? Will there be reductions in the number of faculty? What is your opinion of the loss in momentum that will result because further growth in research funds may be limited to specific targeted research areas?

Health Services and Community Programs

How will the patient care you provide or plan to provide be affected by the change in your institution's fiscal situation? What will be the effect upon your community service activities?

Physical Facilities

How will the elimination of the Federal program of direct grants for construction and its replacement by a program of guaranteed loans and interest subsidy affect your institution? Are there facility requirements that can not be met because of financial difficulties? What programs of your institution will be most seriously affected by physical facility deficiencies?

Alternative Sources of Support

Do you foresee the possibility of obtaining any additional funds for your activities from non-Federal sources, which may reduce the impact of the change in Federal financing?

Questionnaire Forms

Please return all pages of the questionnaire: indicate "None" on those sheets that do not apply to your institution.

Please provide your best estimates for each program of the operating expenditures, the object of expenditures of these funds, the numbers of faculty and supporting personnel employed on these grants and contracts, and the numbers of students on fellowships and training grants, or employed on research grants and contracts.

Regular research grants and research contracts (page 1 to 17)

Investigator-initiated research grants and research contracts, awarded by:

(1) The National Institutes of Health: a separate page for each of the Institutes and Research Divisions, the Bureau of Health Manpower Education, and the National Library of Medicine.

(2) Health Services and Mental Health Administration: a separate page for the National Institute of Mental Health, and one page for all other components of HSMHA.

(3) All other agencies of the Federal Government - aggregated on one page.

Indicate "None" on those pages that do not apply to your institution.

Research Training Grants, Fellowships and Research Career Awards
(page 18 to page 34)

Grants awarded by:

(1) The National Institutes of Health: a separate page for each of the Institutes and Research Divisions, the Bureau of Health Manpower Education and the National Library of Medicine.

(2) Health Services and Mental Health Administration: a separate page for the National Institute of Mental Health, and one for all other components of HSMHA.

(3) All other agencies of the Federal Government - aggregated on one page.

Indicate "None" on those pages that do not apply to your institution.

Capitation and Special Project Grants
(page 35)

Grants awarded by Bureau of Health Manpower and Education, NIH.

Institutional Support Grants
(page 36)

General research support grants, resource center grants, and other special grants, awarded by the National Institutes of Health.

Regional Medical Program and Community Services
(page 37)

Regional medical program grants awarded by Health Services and Mental Health Administration, and medical service grants and contracts funded from state and local governments and other public or private agencies.

Summary - Projected Program Expenditures and Income Sources
(page 38)

A summary recapitulation of the expenditure data provided on the questionnaire, and your estimates of the other sources of income of your institution.

MEDICAL SCHOOL: _____

Narrative Statement

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL CANCER INSTITUTE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL HEART AND LUNG INSTITUTE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF DENTAL RESEARCH, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF ARTHRITIS, METABOLIC AND DIGESTIVE DISEASES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS) -				
	(A)	(B)	(C)	(D)	(E)
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
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** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel
FROM: NATIONAL EYE INSTITUTE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: DIVISION OF RESEARCH RESOURCES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
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MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: DIVISION OF BIOLOGICS STANDARDS, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: BUREAU OF HEALTH MANPOWER AND EDUCATION, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL LIBRARY OF MEDICINE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF MENTAL HEALTH, HSMHA

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION COMPONENTS EXCEPT NIMH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel

FROM: FEDERAL AGENCIES - OTHER THAN NIH AND HSMHA

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regular* research grants, total expenditures (sum of lines 2,3 and 4)					
2. New awards, total					
3. Competitive renewals, total					
4. Non-competitive renewals, total					
5. Research contracts, total expenditures					
6. Total expenditures of research grants and contracts (sum of lines 1 and 5)					
7. Object of expenditures, total**					
8. Faculty salaries					
9. Other Personnel salaries					
10. Other direct costs					
11. Indirect costs					
NUMBER OF PERSONNEL					
12. Faculty, total (sum of lines 13, 14, 15)					
13. Number receiving total salary support from these research grants and contracts					
14. Number receiving more than half but less than total salary support from these research grants and contracts					
15. Number receiving some salary support but less than half from these research grants and contracts					
16. Supporting staff, total number employed on these research grants and contracts					
17. Predoctoral students, total number employed on these research grants and contracts					
18. Postdoctoral students, total number employed on these research grants and contracts					

* Grants to support investigator-initiated research.
** Sum of lines 8, 9, 10, and 11 equals line 6.

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel

FROM: NATIONAL CANCER INSTITUTE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7 Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
	NUMBER OF PERSONNEL				
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel

FROM: NATIONAL HEART AND LUNG INSTITUTE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7 Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF DENTAL RESEARCH, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF ARTHRITIS, METABOLIC AND DIGESTIVE DISEASES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
	NUMBER OF PERSONNEL				
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL EYE INSTITUTE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
	NUMBER OF PERSONNEL				
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: DIVISION OF RESEARCH RESOURCES, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: DIVISION OF BIOLOGICS STANDARDS, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7 Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: BUREAU OF HEALTH MANPOWER AND EDUCATION, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
	NUMBER OF PERSONNEL				
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL LIBRARY OF MEDICINE, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7. Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: NATIONAL INSTITUTE OF MENTAL HEALTH, HSMHA

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7 Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
	NUMBER OF PERSONNEL				
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION COMPONENTS EXCEPT NIMH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7 Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

RESEARCH TRAINING GRANTS, FELLOWSHIPS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
FROM: FEDERAL AGENCIES - OTHER THAN NIH AND HSMHA

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Research training grants, total expenditures (sum of lines 2,3,4,5, and 6)					
2. Faculty salaries					
3. Other personnel salaries					
4. Student stipends					
5. Other direct costs					
6. Indirect costs					
7 Fellowships, total expenditures (sum of lines 8 and 9)					
8. Stipends					
9. Other costs					
10. Career awards, total salaries					
NUMBER OF PERSONNEL					
11. Research Training Grants					
12. Faculty, total (sum of lines 13,14, and 15)					
13. Number receiving total salary support from these grants					
14. Number receiving more than half but less than total salary support from these grants					
15. Number receiving some salary support but less than half from these grants					
16. Supporting staff, total number employed on these grants					
17. Students trained, total number (sum of lines 18,19, and 20)					
18. Predoctoral					
19. Postdoctoral					
20. Other					
21. Fellowships, total number (sum of lines 22 and 23)					
22. Predoctoral					
23. Postdoctoral					
24. Research career awards, total number					

MEDICAL SCHOOL: _____

CAPITATION AND SPECIAL PROJECT GRANTS
Operating Expenditures and Number of Personnel

FROM: BUREAU OF HEALTH MANPOWER AND EDUCATION, NIH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Capitation grants, total (sum of lines 2,3,4, and 5)					
2. Basic capitation					
3. Bonus class support					
4. Graduates in 3 years					
5. Physicians' assistants					
6. Special Project Grants, total (sum of lines 7,8,9,10,11 and 12)					
7. Physician augmentation					
8. Curriculum improvement					
9. Educational technology					
10. Enrollment of minority and low-income students					
11. Financial distress					
12. Other, please specify					
NUMBER OF PERSONNEL					
13. Faculty, total (sum of lines 14, 15, and 16)					
14. Number receiving total salary support from these grants					
15. Number receiving more than half but less than total salary support from these grants					
16. Number receiving some salary support but less than half from these grants					
17. Supporting staff, total number employed on these grants					

MEDICAL SCHOOL: _____

INSTITUTIONAL SUPPORT GRANTS
Operating Expenditures and Number of Personnel

FROM: NATIONAL INSTITUTES OF HEALTH

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	- (OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. General Research support grants, total expenditures					
2. Resource Centers*, total expenditures					
3. Other Special Grants**, total expenditures					
4. Total Expenditures (sum of lines 1,2, and 3)					
5. Object of Expenditures***					
6. Faculty salaries					
7. Other Personnel salaries					
8. Equipment					
9. Other					
NUMBER OF PERSONNEL					
10. Faculty, total (sum of lines 11,12, and 13)					
11. Number receiving total salary support from these grants					
12. Number receiving more than half but less than total salary support from these grants					
13. Number receiving some salary support but less than half from these grants					
14. Supporting staff, total number employed on these grants					

* Categorical and general clinical research centers, pharmacology-toxicology research centers, anesthesiology and diagnostic radiology centers, mental retardation centers, environmental health science centers.

** Animal resource and primate centers, biotechnological resource centers, international centers medical research and training.

*** Sum of lines 6,7,8, and 9 equals line 4.

REGIONAL MEDICAL PROGRAM, COMMUNITY SERVICES
Operating Expenditures and Number of Personnel

Type of Award and Object of Expenditure	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
1. Regional Medical Program, total expenditures (sum of lines 2,3,4, and 5)					
2. Faculty salaries					
3. Other personnel salaries					
4. Other direct costs					
5. Indirect costs					
6. Medical Service grants and contracts from state and local governments, total expenditures (sum of lines 7,8,9,and 10)					
7. Faculty salaries					
8. Other personnel salaries					
9. Other direct costs					
10. Indirect costs					
11. Medical service grants and contracts -- other, total expenditures (sum of lines 12,13,14 and 15)					
12. Faculty salaries					
13. Other personnel salaries					
14. Direct costs					
15. Indirect costs					
NUMBER OF PERSONNEL					
16. Faculty, total					
17. Number receiving total salary support from these grants and contracts					
18. Number receiving more than half but less than total salary support from these grants and contracts					
19. Number receiving some salary support but less than half from these grants and contracts					
20. Supporting staff total number employed on these grants and contracts					

MEDICAL SCHOOL: _____

SUMMARY: PROJECTED PROGRAM EXPENDITURES AND INCOME SOURCES

Expenditures and Income Sources	FY 1972 Actual	FY 1973 Original Estimate	FY 1973 Present Estimate	FY 1974 Original Estimate	FY 1974 Present Estimate
	(OPERATING EXPENDITURES IN THOUSANDS OF DOLLARS)				
	(A)	(B)	(C)	(D)	(E)
	From Questionnaire				
1. Federally sponsored programs					
2. Regular research grants (sum of line 1 pages 1 to 17)					
3. Research contracts (sum of line 5 pages 1 to 17)					
4. Research training grants (sum of line 1 pages 18to 34)					
5. Fellowships (sum of line 7 pages 18to 34)					
6. Career awards (sum of line 10 pages18to 34)					
7. Capitation grants (line 1 page 35)					
8. Special project grants (line 6 page 35)					
9. General research support grants (line 1 page 36)					
10. Resource center grants (line 2 page 36)					
11. Other special grants (line 3 page 36)					
12. Regional medical program (line 1 page 37)					
13. Medical Service grants and contracts					
14. State and local (line 6 page 37)					
15. Other (line 11 page 37)					
OTHER INCOME - Thousands of Dollars					
16. State and local govt. appropriations					
17. Sponsored research non-federal					
18. Sponsored teaching and training non-federal					
19. Student tuition and fees					
20. Medical service plan income					
21. Endowment income					
22. Gifts					
23. Other income					
24. Federal					
25. State and local					
26. Other					

Handout (1)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

[CAS Dept al. Survey]

March 16, 1973

TO: Chairmen of the Departments Participating in the CAS Survey

FROM: August G. Swanson, M.D. and Michael F. Ball, M.D.

SUBJECT: AAMC Survey of the Impact of the Proposed FY 73 and 74 Federal Health Budget

This questionnaire has been developed for five disciplines and may include categories which are not applicable to your department. Please provide as much information as possible and indicate those instances in which you may have lumped sources together. Please also indicate in an accompanying narrative any information which you feel may be helpful.

Data for fiscal year 1972 and 1973 should reflect the current status of funding. Data for fiscal year 1974 should reflect your best estimate of the situation as viewed from the perspective of March, 1973. The FY 74 data should include your best guess as to alternate sources of funding and your chances of obtaining new funding.

We have requested fiscal data in categories which will allow the best presentation of our case to the legislature. In some instances, it may not be possible to provide the detail we have requested. For example, in some schools state funds are channeled through the dean's office and are indistinguishable from other school funds. In contrast, in other schools the department chairmen have full knowledge of the origin of all of their funds. Please provide as specific information as possible and indicate various instances in which you have lumped sources together.

The data you provide will be extraordinary useful for presenting our case to the legislature at both the national and state levels. We anticipate that the Appropriations Committee hearings will begin shortly and urge that the completed questionnaire be returned as quickly as possible.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MARCH 16, 1973 CAS BRIEFS NO. 17

THIS CAS Brief is part of the series of the Association's activities established by the Executive Committee to gather information on the effects of Administration budget proposals for FY 1973 and FY 1974 on the medical schools. The overall strategy was outlined in Memorandum #73-5.

IN this document, we are providing the latest information available from the various Federal agencies on the way in which the budget proposals will be implemented. Although we believe the information we have been able to gather is reliable, unfortunately it is incomplete for some programs where operating decisions have not yet been made. It must be recognized that current program plans are subject to later policy changes, Congressional action on appropriations for health programs in DHEW for FY 1973 and FY 1974 and the expenditures of these funds permitted by the Office of Management and Budget.

ON the basis of the information provided in this Brief, together with that previously distributed in Memorandum #73-6, we are asking each department to estimate the impact of the Administration's proposed FY 1973 and FY 1974 budgets on its programs and activities. You may already have answered these questions as part of a similar survey on an institution by institution basis. The purpose of this study is to pinpoint the effect of the changes in funding on those disciplines which seem to be at greatest risk.

THE questionnaire has been designed to gather information on those program changes that appear to have the greatest impact. Information is also requested on changes in other sources of financing, such as state support, to permit an evaluation of the total impact of all changes. It is quite likely that you do not have all of the information readily available. It is hoped that you will make the best estimates you can for data not on hand. We must balance the need for a relatively prompt response against the delay that would result from an exhaustive study in each institution to provide the information.

WE have not asked for information on the effects of H.R 1 on medical service income since the guidelines for implementing the provisions of that legislation are not yet available. Data is not being sought on Maternal and Child Health Services and children and youth programs since project grants are being folded into State formula grants and the consequences of this change are not yet clear. When there is a basis for making a judgment, additional information will be requested.

AN attempt was made to establish the level of information necessary to develop an assessment of impact and yet which would not overwhelm the institutions in providing a response. If there are changes in other sources of support that will have serious effects on your institution, we would like to have you describe them separately in whatever detail you can.

COUNCIL OF ACADEMIC SOCIETIES

I cannot stress too strongly the importance of the information we are requesting for making the case for more adequate financial support of the medical schools. Rhetoric alone will not serve our purposes in discussions with the Administration and the Congress. Without more data and facts, we will not be able to properly serve your interests. The study we are undertaking will be useful not only in providing aggregate information, but in discussions at the local level and with Congressmen and Senators about individual institutions. It will also help you plan for the anticipated fiscal crunch.

FOR maximum success, we need a 100 percent response. There are severe time constraints if we are to use the information in attempting to get changes in the FY 1973 levels of support. Therefore, we hope that you will be able to return the completed questionnaire by March 31, 1973.

PLEASE do not hesitate to call me if you have any questions. For specific questions relating to guideline information, please call Prentice Bowsher - (202) 466-5190; for specific questions relating to the questionnaire, please call Dr. Michael Ball, (202) 466-5152.

COUNCIL OF ACADEMIC SOCIETIES # #

INSTRUCTIONS FOR COMPLETING
SECTION ONE OF THE AAMC IMPACT QUESTIONNAIRE

1. Non-federal Grants and Contracts: Please include all non-federal grants and contracts funded from private foundations, non-profit organizations, etc. Do not include state or local government grants or contracts.

2. Medical School Funds: Please include in this column all support derived from the medical school which is not specifically earmarked as to source. For example, if you can specifically identify the source of funding, it should be entered in the appropriate column, i.e., state funds, general research support, or patient care fees. Funds identified to the department solely as 'dean's budget' or 'school budget' should be entered here and need not be traced further as to source.

3. State and Local Funds: Include in this column all grants, contracts and institutional support derived from the state, county or local government which can be identified as such. Do not include support provided as direct remuneration for delivery of patient care or for services rendered to a city hospital for which direct salary support is provided, i.e., salary as a chief of a laboratory in the city hospital or as chief of radiology in the city hospital.

4. Departmental Funds: Include all funds which accrue to the department directly as a result of gifts, payment for laboratory tests or any of the myriad of non-specific direct departmental support. The primary control of this support should be at the departmental level rather than the school level.

5. Hospital Funds: Include support which is derived from the hospital budget for rendering services, i.e., directing an outpatient department, supervising a laboratory or working in an emergency room. Do not include support derived from the direct delivery of patient care (fee for services or professional fee remuneration). Include in this column support from a city hospital for individuals serving as chief medical officer or chief of a laboratory.

6. Patient Care Fees: Include all support derived from direct delivery of patient care.

7. NIH/NIMH Research Grants, Contracts and Center Awards: I believe this section is self-explanatory.

8. NIH/NIMH Training Grants: Include training grants, career development awards, career teacher awards, career awards of all types and the various kinds of special federal fellowships.

9. General Research Support Grants (GRS): I believe this is also self-explanatory and should be identified to the degree possible.

10. Manpower Special Projects: Include to the degree possible support derived from capitation, physician augmentation, disaster funds and the various types of incentive and developmental grants or contracts.

11. Veterans Administration: Include all support derived directly from the Veterans Administration even though it does not go through the university budget.

12. Other: Include both federal and non-federal support which cannot be readily assigned to one of the other categories.

13. All Sources Total: I believe this is self-explanatory.

A. Faculty Salaries: Include the dollar value of faculty salaries for all full-time and part-time faculty. Data should be provided based on the FY 72 experience, current FY 73 expenditure levels and anticipation for FY 74.

B. Number of Full-time Faculty: Provide the number of paid faculty full-time and part-time expressed as full-time equivalents. This means that five faculty members spending 1/3 of their time at the university and 2/3 of their time in private practice unrelated to the academic health center would be considered as 1 and 2/3 faculty. Please indicate the number of faculty in your department broken down into categories as tenured and non-tenured in the lower right hand portion of the page so that we may more precisely indicate the area of impact.

C. Trainee Stipends: Trainee stipends should not include house staff salaries unless the resident salary is provided directly from a training grant. Resident stipends derived from the hospital budget should not be included. However, include whether it is supported by NIH or NIMH training grants.

D. Number of Trainees: The number of trainees should be expressed as number of persons supported. It should not be expressed in terms of full-time equivalents.

E. Staff Salaries: Include the funding for clerical and administrative staff personnel.

F. Program Support: Include all additional support including technical and research personnel, instrumentation and supplies.

SECTION I
AAMC SURVEY OF THE IMPACT OF CHANGES IN FUNDING

DEPARTMENTAL BUDGET (In Thousands of Dollars)

	NON-FEDERAL						FEDERAL						
	Grants and Contracts 1	Medical School Funds 2	State/Local Funds 3	Departmental Funds 4	Hospital Funds 5	Patient Care Fees 6	NIH/NIMH Research Grants, Contracts and Center Awards 7	NIH/NIMH Training Grants 8	GRS 9	Manpower Special Projects 10	VA 11	Other 12	ALL SOURCES TOTAL 13
A. FACULTY SALARIES ($)													
FY 72													
FY 73													
FY 74													
B. NUMBER OF FULL-TIME FACULTY (FTE)													
FY 72													
FY 73													
FY 74													
C. TRAINEE STIPENDS* ($)													
FY 72													
FY 73													
FY 74													
D. NUMBER OF TRAINEES*													
FY 72													
FY 73													
FY 74													
E. STAFF SALARIES ($)													
FY 72													
FY 73													
FY 74													
F. PROGRAM SUPPORT ($)													
FY 72													
FY 73													
FY 74													

* Do not include house staff unless supported by a training grant

SCHOOL_____

DEPARTMENT_____

No. of Trainees	Pre-doct.	Post-doct.
FY 72		
FY 73		
FY 74		
No. of Faculty	**Tenured**	**Non-tenured**
FY 72		
FY 73		
FY 74		

SURVEY OF CHANGING PATTERNS OF FEDERAL FUNDING

SECTION II

1.

(a) What percentage of your faculty budget is derived from obligations to provide services, e.g., run a bacteriology lab, deliver health care, etc.

_____%

(b) What percentage of your faculty budget is derived from obligations to carry out education?

_____%

(c) What percentage of your faculty budget is derived from obligations to conduct research?

_____%

(d) What percentage of your faculty budget is devoted to graduate (post M.D., Ph.D.) training?

_____%

2. Indicate the expected losses or gains in the following personnel in your department that you anticipate if funding patterns for your department continue as you currently perceive them (do not base decisions on non-specified general proposals which have no strong likelihood of materializing).

Faculty Rank	Current 72-73	73-74	74-75
Senior (Professional)			
Junior (Instructor)			
Post Doctorals			
Ph.D.			
Residents			
Graduate Students			
Medical Students (Free time research activity)			
Technicians			
Other (Specify)			

3. On the basis of potential funding changes, indicate for each year, using the scale of 0 to 5, what impact changes in funding will have on your program.

Scale

0 - cannot predict

1 - drastic negative effect

2 - moderate negative effect

3 - no effect

4 - moderate positive improvement

5 - very positive improvement

	Current 1972-1973	1973-1974	1974-1975
MEDICAL STUDENT TEACHING			
Quality overall			
Contact hours (Faculty/Student)			
Content of Program			
Innovation of Program			
Other (Specify)			
ALLIED HEALTH TEACHING			
Quality overall			
Contact hours (Faculty/Student)			
Content of Program			
Improvement of Program			
Innovation of Program			
Other (Specify)			

3. Continued.....	Current 1972-1973	1973-1974	1974-1975
GRADUATE STUDENT TEACHING			
Quality overall			
Contact hours (Faculty/Student)			
Content of Program			
Improvement of Program			
Innovation of Program			
Other (Specify)			
POST DOCTORAL (PH. D) PROGRAMS			
Quality overall			
Contact hours (Faculty/Student)			
Content of Program			
Improvement of Program			
Innovation of Program			
Other (Specify)			
RESIDENTS			
Quality overall			
Contact hours (Faculty/Student)			
Content of Program			
Improvement of Program			
Innovation of Program			
Other (Specify)			

3. Continued....

	Current 1972-1973	1973-1974	1974-1975
RESEARCH			
Total output			
Initiation of new approaches			
Collaborative studies			
SERVICE			
Delivery of health services			
Development of new approaches			
LOSS OR GAIN OF BEST FACULTY			
OTHERS			

4. Do the changes in fiscal funding and your answers to the above questions portray the impact of the proposed FY 73 and 74 budgets on your programs?

/__/ YES /__/ NO

If NO, please elaborate

[CAS & Accreditation]

The following individuals have responded to the January 9, 1973 CAS Brief #14, to volunteer to serve on the Liaison Committee on Medical Education site visit teams.

The
University of Oklahoma Health Sciences Center
Post Office Box 26901 Oklahoma City, Oklahoma 73190

DEPARTMENT OF PSYCHIATRY
AND BEHAVIORAL SCIENCES
800 N.E. 13th Street

January 29, 1973

August Swanson, M. D.
Director, Academic Affairs
Association of American Medical Colleges
Suite 200
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Dr. Swanson:

I am responding to the notice in the CAS Brief #14 regarding greater involvement of persons in the academic community in site visits with the liaison committee on medical education for accreditation. I would be interested in participating in this program and willing to be placed on the roster of site visitors as a representative of the Council of Academic Societies. This is an important activity and is directly related to my long standing interest in medical education and my present involvement in coordinating interdisciplinary educational programs for medical students at the University of Oklahoma Health Sciences Center. I would consider it an honor to participate and an opportunity to not only contribute, but to learn.

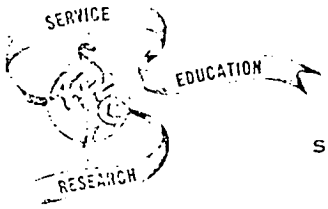
Sincerely yours,

F. Marian Bishop

F. Marian Bishop, Ph. D.
Professor

FEB 02 1973

Dr. Schofield



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 20, 1973

F. Marian Bishop, Ph.D.
Professor
Department of Psychiatry and
Behavioral Sciences
800 N.E. 13th Street
The University of Oklahoma Health
Sciences Center
Oklahoma City, Oklahoma 73190

Dear Marian:

I appreciate your interest in participating as a site visit member for the Liaison Committee on Medical Education. I have forwarded your letter to Marjorie Wilson, head of our Department of Institutional Development. Marjorie will place your name on the roster.

Sincerely yours,

August G. Swanson, M.D.
Director of Academic Affairs

AGS/sd
dictated but not seen

cc: Dr. Marjorie Wilson ✓

UNIVERSITY of PENNSYLVANIA
PHILADELPHIA 19104

School of Medicine
DEPARTMENT OF OTOLARYNGOLOGY
3400 Spruce Street

February 13, 1973

August Swanson, M.D.
Associate of American Medical Colleges
Suite 200
1 DuPont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Swanson:

I am interested in participating in the Site Visits for the Liaison Committee on Medical Education.

With best regards.

Sincerely,

James B. Snow, Jr., M.D.
CAS Representative for the Society of University Otolaryngologists

JBS:jms

Dr. Schofield

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 20, 1973

James B. Snow, Jr., M.D.
Department of Otolaryngology
University of Pennsylvania
School of Medicine
3400 Spruce Street
Philadelphia, Pennsylvania 19104

Dear Dr. Snow:

Thank you for informing me of your interest in participating in site visits for the Liaison Committee on Medical Education. I have passed your letter on to Dr. Marjorie Wilson, Director of the Department of Institutional Development. She will add your name to the roster.

Sincerely yours,

August G. Swanson, M.D.
Director of Academic Affairs

AGS/sd
dictated but not seen

cc: Dr. Marjorie Wilson

SCHOOL OF MEDICAL SCIENCES
PACIFIC MEDICAL CENTER, Clay and Webster Streets
P. O. Box 7999, San Francisco, CA 94120 • (415) 921-1055

January 15, 1973

August G. Swanson, M.D.
Director, Department of Academic Affairs
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D. C. 20036

Re: Site Visits for Liaison Committee on Medical Education

Dear Gus:

At the risk of committing myself to something that I know is a time-consuming and somewhat difficult task, I would like to be considered as a potential member of a site visit team (by virtue of my representation on the Council of Academic Societies or whatever criteria).

I do have a great interest and involvement in the broad aspects of educational design and development and implementation and would welcome the opportunity to participate in and learn more about the accreditation process.

Sincerely,

Bruce E. Spivey MD

Bruce E. Spivey, M.D.
Dean

BES:jec

JAN 18 1973

Dr. Schofield

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 20, 1973

Bruce E. Spivey, M.D.
Dean
School of Medical Sciences
Pacific Medical Center
Clay and Webster Streets
P. O. Box 7999
San Francisco, California 94120

Dear Dr. Spivey:

Thank you very much for informing me of your interest in being placed on the roster of site visit team members for the Liaison Committee on Medical Education. I have passed your letter on to Dr. Marjorie Wilson, Director of the Department of Institutional Development.

Sincerely yours,

August G. Swanson, M.D.
Director of Academic Affairs

AGS/sd
dictated but not seen

cc: Dr. Marjorie Wilson ✓ noted · mw

UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE
DEPARTMENT OF PATHOLOGY
CHARLOTTESVILLE, VIRGINIA 22903

January 12, 1973

Augustus G. Swanson, M.D.
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Swanson:

I am writing in response to the request in the January 9th "CAS Briefs" for persons interested in participating in accreditation visits. I have lately been interested in objective measurement of the excellence of medical schools, and would appreciate the opportunity to engage in this work.

Sincerely,

Martin G. Netsky, M.D.
Professor of Neuropathology

MGN/bcs

JAN 15 1973

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 18, 1973

Martin G. Netsky, M.D.
Professor of Neuropathology
School of Medicine
University of Virginia
Department of Pathology
Charlottesville, Virginia 22903

Dear Dr. Netsky:

I am replying to your letter of January 12 regarding your interest in participating in accreditation visits for the Liaison Committee on Medical Education. I will place your name on the panel and inform Dr. Wilson of your interest.

Sincerely yours,

August G. Swanson, M.D.
Director of Academic Affairs

AGS/sd

cc: Dr. Wilson