

AGENDA FOR COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

Thursday, June 21, 1973

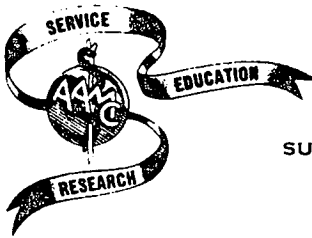
9:30 AM - 3:30 PM

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

CAS ADMINISTRATIVE BOARD

AGENDA

June 21, 1973
9:30 am - 3:30 pm

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

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MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

March 15, 1973

AAMC Headquarters
Washington, D.C.

PRESENT: Board Members

Robert G. Petersdorf, Chairman (Presiding)
Robert M. Blizzard
David R. Challoner
**Sam L. Clark, Jr.
Ludwig Eichna
Ronald W. Estabrook
Robert E. Forster, II
Rolla B. Hill, Jr.

Staff

Michael F. Ball
*L. Thompson Bowles
Connie Choate
*John A.D. Cooper
Mary H. Littlemeyer
August G. Swanson

ABSENT: Board Members

Charles F. Gregory
**Ernst Knobil
William B. Weil, Jr.

Guest

*Charles B. Womer

I. Adoption of Minutes.

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

II. Chairman's Report.

Dr. Petersdorf reported on the AAMC's efforts in reacting to the Administration's budget proposals for FY/73 and FY/74. The AAMC Executive Committee decided that the Association should proceed deliberately, fully assessing on an institution-by-institution basis the impact of the budget

*For part of meeting
**Ex Officio

proposals on its programs and activities. A comprehensive, extensive analysis of the way in which the budget proposals will be implemented was mailed to each school in late February with a survey to elicit the data. A supplementary questionnaire has been distributed to chairmen of departments of medicine, pediatrics, psychiatry, physiology, microbiology, and biochemistry to permit an estimate of the impact of the Administration's budget proposal on these specialties.

The Executive Committee met with Mr. Weinberger one week before the budget was announced. He reviewed a background paper on medical education developed by AAMC. The Executive Committee also met with James Cavanaugh, health adviser to the President's Domestic Council. In addition, Dr. John Cooper has met with Senator Hubert Humphrey; Congressman George Mahon, Chairman of the House Appropriations Committee; Congressman Robert Michel, Ranking Minority Member of the House HEW Appropriations Subcommittee; and Harley Dirks of the Senate HEW Appropriations Subcommittee staff. All have praised the AAMC's efforts to collect definitive information on the effects of the President's proposed budget cuts and have indicated great interest in reviewing the results of the AAMC's institutional questionnaire.

III. Action Items.

1. Report of Graduate Medical Education Committee.

The Administrative Board reviewed the Report of the Graduate Medical Education Committee: Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education. This document was developed to be used for graduate medical education as a general guidelines document, much as the "Functions and Structures" document is used for undergraduate medical education.

ACTION: The CAS Administrative Board unanimously approved the Report of the Graduate Medical Education Committee.

2. Report of Continuing Medical Education Committee

The Report of the Ad Hoc Committee on Continuing Medical Education was developed in response to its charge to advise the AAMC regarding the role the Association and its constituents should play in continuing education in the future.

ACTION: The CAS Administrative Board unanimously approved the Report of the Continuing Medical Education Committee with the stipulation that the paragraph on financing should be strengthened, i.e., schools have finite resources, and basic programs should not be threatened.

NOTE: At its meeting the following day, The Executive Council did not approve a report of the Ad Hoc Committee on Continuing Education but adopted five recommendations contained in the paper and directed the committee to use these recommendations as the basis for a new report regarding the role of the AAMC and its constituents in continuing education. The approved recommendations state that: (1) medical faculties have a responsibility to impress upon students that the process of self-education is continuous; (2) medical faculties must cooperate with practicing physicians to develop criteria of optimal clinical management of patient problems; (3) educational programs must be specifically directed toward improving detected deficiencies; (4) evaluation of the effect of educational programs should be planned from their inception; and (5) financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.

3. Selection of Nominating Committee

ACTION: The CAS Administrative Board selected a list of 14 names from which the membership will choose seven to comprise the CAS Nominating Committee. They are:

James F. Ashmore, Ph.D., Chairman
Department of Pharmacology
Indiana University

Ellis S. Benson, M.D., Chairman
Department of Clinical Pathology
University of Minnesota

Sam L. Clark, Jr., M.D., Chairman
Department of Anatomy
University of Massachusetts

John Corcoran, Ph.D., Chairman
Department of Biochemistry
Northwestern University

Douglas W. Eastwood, M.D.
Director of Research in Medical Education
Case Western Reserve University

Arthur B. Otis, Ph.D., Chairman
Department of Physiology
University of Florida

Howard M. Rawnsley, M.D.
Professor of Pathology & Medicine
University of Pennsylvania

R. Walter Schlesinger, M.D., Chairman
Department of Microbiology
Rutgers University

G. Thomas Shires, M.D., Chairman
Department of Surgery
University of Texas-Southwestern

James F. Toole, M.D., Chairman
Department of Neurology
Bowman Gray

Nancy E. Warner, M.D., Chairman
Department of Pathology
University of Southern California

James V. Warren, M.D., Chairman
Department of Medicine
Ohio State University

Louis G. Welt, M.D., Chairman
Department of Medicine
Yale University

Ralph J. Wedgwood, M.D., Chairman
Department of Pediatrics
University of Washington

It was noted that the individual receiving the largest number of votes becomes Chairman of the CAS Nominating Committee and also a member of the AAMC Nominating Committee.

The limitations of the current rules and regulations pertaining to the selection and function of the Nominating Committee were reiterated.

Dr. Swanson and Dr. Ball were authorized to draft alternatives to the rules and regulations that currently pertain in this regard.

4. AAMC RMP-CHP Legislative Proposal

The CAS Administrative Board reviewed the following principles that were proposed to be adopted as AAMC policy on the extension of legislative authorizations for the Regional Medical Program and for the Comprehensive Health Planning Programs which expire June 30, 1973:

a. 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.

b. 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 transfer 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.

c. 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.

ACTION: The CAS Administrative Board questioned the wisdom of the AAMC making an effort in this direction at this time.

NOTE: The Executive Council did not approve this proposal at its meeting on March 16.

5. Policy Statement of AAMC on Professional Standards Review Organizations (PSROs).

ACTION: The CAS Administrative Board unanimously approved 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 Professional Standards Review Organizations.

6. Membership Applications.

ACTION: The CAS Administrative Board unanimously recommended that membership applications of the following be approved for transmission to the Council:

- a. American Academy of Orthopedic Surgeons
- b. American College of Chest Physicians
- c. American Society of Therapeutic Radiologists
- d. American Urological Association

7. Annual Meeting.

The CAS Board named several possible topics to which the CAS Annual Meeting

(a one-half day session) might be devoted. Among these were: medical ethics and human experimentation, assessment and testing, the PSRO problem, management responsibility of faculty to other programs of the health science center, and primary care. Also suggested was the impact of contract grants, which was not favored because of the focus of the special March Workshop.

V. Information Items.

Mr. Charles B. Womer, Executive Director of Yale-New Haven Hospital, reported on progress of the AAMC Ad Hoc HR 1 Committee in negotiations with the SSA. The committee has been encouraged by the SSA's cooperation in their meetings.

Dr. John A.D. Cooper met with the Board at lunch and discussed in detail AAMC activities alluded to in Dr. Petersdorf's report with a current reading of the federal scene vis-a-vis the Omnibus Bill (Kennedy), "National Health Research Fellowship and Traineeship Act of 1973" (Rogers Bill), SSA, and VA, to name a few.

Dr. Ronald Estabrook reported that the Biomedical Research Committee had held two meetings. The committee has attempted to address the following issues:

1. How much of the research budget is essential to the program of medical education?
2. How much research is necessary to the educational environment or to make a good faculty?

Dr. Rolla Hill reported on the Educational Resources Program Advisory Committee's first meeting which was a planning session for the multimedia accession and indexing project.

The CAS Brief calling for names of those interested in serving on accreditation teams had a limited response. A more productive approach was

thought to be via the Administrative Board, who could suggest names of individuals personally known as good resources. As the situation evolved, it was not necessary to appoint the ad hoc committee earlier authorized by the Board (See Minutes 12/14/72, page 3).

In response to the suggestion at the last Board meeting, a "structure and function" kit describing CAS was developed which appears as the introduction to the CAS Directory recently distributed to the membership.

Dr. David Challoner discussed his "Approach to Support of Postdoctoral Training," which represents an attempt to identify the beneficiaries of biomedical postdoctoral clinical and research training programs with a subsequent suggestion of a corresponding allocation of costs. Dr. Challoner invited reactions from the Board and indicated that he would be willing to develop data during a sabbatical he has coming up. Dr. Eichna was not optimistic that faculty positions would be available when the faculty would be trained and available to the schools.

The Board noted Dr. Blizzard's letter to Pediatric Chairmen urging continued membership in the CAS. The organization did elect to maintain its membership.

Dr. Ball queried the Board about the value of the pre-Board dinner meetings. The consensus was that these meetings are extremely useful and that only a full Board commitment to attend these sessions would warrant them.

VI. Adjournment.

The meeting was adjourned at 3:35 p.m.

AAMC POLICY STATEMENT

THE PATIENT IN THE TEACHING SETTING

The medical faculties and staff of the nation's medical schools and teaching hospitals are committed to the provision of the highest quality of personal health services. The interrelationship between the health care, educational and research functions of these institutions contribute to the assurance of these high standards of patient care. Patients seeking care in the teaching setting are not only provided high quality health services, but also an opportunity to share in the training of the nation's future health care professional personnel through participation in clinical education.

It is the policy of the Association of American Medical Colleges that all patients, regardless of economic status, service classification nature of illness or other categorization should have the opportunity to participate in the clinical education program of the hospital, clinic or other delivery setting to which they are admitted or from which they seek care.

In order to assure a single standard of high quality patient care, and to reinforce student perspectives and attitudes regarding patient rights and responsibilities, the AAMC reaffirms that:

- . Selection of patients for participation in teaching programs shall not be based on the race or socioeconomic status of the patient.
- . Responsible physicians have the obligation to discuss with the patient both general and specific aspects of student participation in the medical care process.

- . Provision of patient care is a confidential process.
Relationships between the patient, health professional and student, regarding examinations, treatment, case discussion and consultations should be treated with due respect to the patient's right to privacy.
- . Each patient has the right to be treated with respect and dignity. Individual differences, including cultural and educational background, must be recognized in designing each patient's care program.
- . Every teaching institution should have programs and procedures whereby patient grievances can be addressed in responsive and timely fashion.

The Association of American Medical Colleges believes that the reaffirmation of these principles in medical schools and teaching hospitals will contribute to the best interests of patients and ensure the most appropriate educational environment for the training of future health professionals.

Affirmed by the Board of Trustees
of the
American Hospital Association
November 17, 1972

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35M-1/73-2659

THE American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the

start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation,

service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.
11. The patient has the right to

examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease; the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

Statement on a Patient's Bill of Rights



RESOLUTIONS

Adopted by the
GOVERNING COUNCIL
of the
AMERICAN PUBLIC HEALTH ASSOCIATION
November 15, 1972

Group C—MANPOWER AND TRAINING

Increased Utilization of Dental Auxiliaries

Supporting Statement

The acute shortage of dental manpower in the United States cannot be alleviated economically solely by the training of additional numbers of dentists. Thus, the productivity of the available dentists must be increased. Although great advances in dental technology have been made in the past two decades, the major factor in increasing the productivity of dentists has been the increased use of dental auxiliaries. Recent studies have shown that properly trained auxiliaries can perform additional duties, maintain a comparable quality of services, and generate substantial increases in the productivity.

Resolution

The expanded utilization of dental auxiliaries appears to be the most practical, economical, and efficient approach to delivering high-quality dental care to more people.

The American Public Health Association recommends and urges that a program of federal support be implemented for the accelerated development of training programs to expand the function of dental auxiliaries, such programs to include support for construction of facilities, operation of programs, training of faculties, and financial incentives to dental schools that teach students the use of expanded function auxiliaries, and be it further resolved, that each state dental society and board of examiners be urged that formal programs of continuing education be developed to prepare presently practicing dentists to utilize expanded function auxiliaries.

Expanded Role of the Nurse in Health Care

Traditional patterns in the delivery of health care are changing rapidly. One of the most positive and potentially beneficial innovations in personal utilization involves the expanded role of the nurse in primary care.

This concept, which was accepted by APHA's Governing Council in 1970, has gained widespread support from the health community, as well as the public. However there has been an unplanned proliferation of short-term training programs to prepare nurse practitioners without the concomitant development of standards to provide adequate safeguards for the practitioner and the public.

APHA reaffirms and extends its position in regard to the utilization of the nurse in extended medical and nursing functions. Specifically, APHA recommends that:

- The expanded role of nurses in medical and health care be developed jointly by the professionals in medicine and nursing;

- Guidelines and standards for programs to prepare the nurse in an expanded role should continue to be developed and refined by national nursing organizations and medical specialty groups;
- Experimentation continue under the auspices of duly accredited institutions;
- Affiliates stimulate the development of responsible educational programs within established guidelines and the appropriate use of practitioners who have successfully completed such programs.

Selection of Teaching Patients

For over a century most of the patients chosen for clinical teaching in medicine, dentistry, and other related health fields, have been so selected, directly or indirectly, because they are poor. In addition, the majority of these patients have been designated as teaching cases without choice on their part. The justification of such selection has been that teaching services have provided health care services to many who could not have otherwise afforded it. While there are still many who cannot obtain adequate health care, the American Public Health Association considers this means of designating patients for clinical teaching programs undesirable.

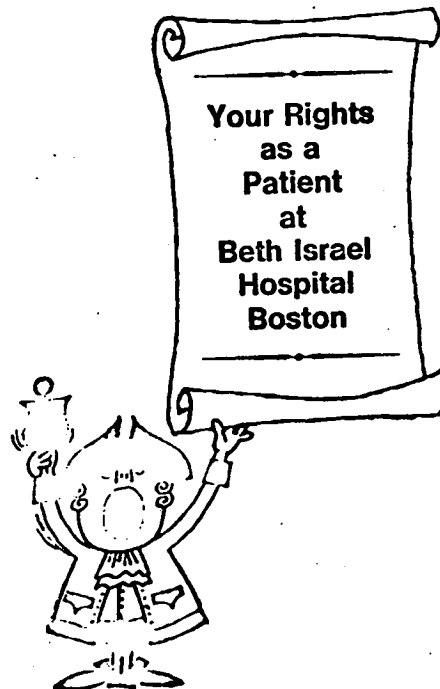
The present means of selecting teaching patients perpetuates a two-class health system which is based upon income and social status. Not only is this socially undesirable, but it is particularly inappropriate in settings where student practitioners are developing perspectives which will persist throughout their professional lives. Most important, however, selection based on economic criteria is inconsistent with the goal of APHA to assure equality of access to and quality of health care for all.

APHA urges the American Medical Association, American Osteopathic Association, the American Hospital Association, the American Dental Association, the American Association of Dental Schools, the Association of American Medical Colleges, the National League for Nursing, and other appropriate professional associations to join with APHA in instituting such resolutions as:

1. Participation of all patients in clinical teaching programs shall be based on the prior approval by each patient, and
2. Selection of patients for teaching programs shall not be based on the race or socioeconomic status of the patient.

Restoration of Environmental Manpower Training Funds

The Environmental Protection Agency, in response to an apparent surplus of certain types of engineers, has curtailed funds designated for graduate level, professional training of categorical specialists in such fields as solid wastes management, radiation protection, water pollution control, and air pollution control.



Your Rights as a Patient at Beth Israel Hospital Boston

Beth Israel Hospital, its doctors, nurses and entire staff are committed to assure you excellent care as our patient. It has always been our policy to respect your individuality and your dignity. This listing is published to be certain that you know of the long-standing rights that are yours as a Beth Israel patient.

1. You have the right to the best care medically indicated for your problem, that is, to the most appropriate treatment available without considerations such as race, color, religion, national origin or the source of payment for your care.

2. You have the right to be treated respectfully by others; to be addressed by your proper name and without undue familiarity; to be listened to when you have a question or desire more information and to receive an appropriate and helpful response.

3. You have the right to expect that your individuality will be respected and that differences in cultural and educational background will be taken into account.

4. You have the right to privacy. In the clinics, you should be able to talk with your doctor, nurse, other health worker or an administrative officer in private, and know that the information you supply will not be overheard nor given to others without your permission. In the Hospital, when you are in a semi-private room, you can expect a reasonable attempt to keep the

conversation private. When you are examined, you are entitled to privacy — to have the curtains drawn, to know what role any observer may have in your care, to have any observers unrelated to your care leave if you so request. If you are hospitalized, no outsiders can see you without your permission. Your hospital records are private as well, and no person or agency beyond those caring for you can learn the information in your medical record without your specific permission.

5. You have the right to know the name of the doctor who is responsible for your care; to talk with that doctor and any others who give you care; to receive all the information necessary for you to understand your medical problems, the planned course of treatment (including a full explanation about each day's procedures and tests) and the prognosis or medical outlook for your future; to receive adequate instruction in self-care, prevention of disability and maintenance of health. You have the right to ask the doctor any questions that concern you about your health. You have the right to know who will perform a test or an operation, and the right to refuse it. Because this is a university hospital, you may come across doctors, nurses and other health workers in training, or you may be asked to participate in special studies. We believe that the presence of students adds to the quality of care. Nevertheless, you have the right to have a full explanation of any research study or any training program for students before you agree to participate in it, and the right to refuse to participate. If you

agree to the diagnostic and therapeutic procedures recommended by your doctor, you may be asked to sign a consent form, but if you refuse, you have the right to receive the best help that the Hospital can still offer under the circumstances.

6. You have the right to leave the Hospital even if your doctors advise against it, unless you have certain infectious diseases which may influence the health of others, or if you are incapable of maintaining your own safety, as defined by law. If you do decide to leave before the doctors advise, the Hospital will not be responsible for any harm that this may cause you and you will be asked to sign a "Discharge Against Advice" form.

7. You have the right to inquire about the possibility of financial aid to help in the payment of your Hospital bills and the right to receive information and assistance in securing such aid.

Patients also have certain responsibilities which should be carried out in their own best interests:

Please keep appointments, or telephone the Hospital when you cannot keep a scheduled appointment; bring with you information about past illnesses, hospitalizations, medications and other matters relating to your health; be open and honest with us about instructions you receive concerning your health, that is, let us know immediately if you do not understand

them or if you feel that the instructions are such that you cannot follow them.

You have the responsibility to be considerate of other patients, and to see that your visitors are considerate as well, particularly with reference to noise and smoking, which are usually very annoying to nearby patients.

You also have a responsibility to be prompt about payment of Hospital bills, to provide information necessary for insurance processing of your bills, and to be prompt about asking any questions you may have concerning your bills.

Beth Israel Hospital is interested in keeping you in the best health possible. If you feel you are not being treated fairly or properly, you have the right to discuss this with your doctor, nurse, unit manager, other health worker, or the Assistant Director on Call. You may also write a letter to the General Director, Beth Israel Hospital, Boston 02215. All correspondence will receive prompt and personal attention.

This message reflects the interest and philosophy of the entire staff of Beth Israel Hospital.

Mitchell T. Rabkin, M.D.

Mitchell T. Rabkin, M.D.
General Director

III. Action Items:

2. Proposal for Modification of Nominating Committee

At present, the CAS Nominating Committee is described in the CAS Rules and Regulations as follows:

Section V. Committees

1. There shall be a Nominating Committee of seven (7) members. Said Committee will be chosen by mail ballot. A ballot listing 14 representatives will be prepared by the Administrative Board and sent to all representatives to the Council. Seven (7) names shall be selected from the list by each representative and submitted to the Secretary. The seven (7) representatives receiving the largest number of votes will constitute the Nominating Committee, except that no member society shall have more than one (1) representative on the Nominating Committee.

The Committee shall meet in person and submit each year to the Secretary forty-five (45) days prior to the annual meeting of the Council of Academic Societies the names of two (2) candidates for each office to be filled. The chairman of the committee will verify in advance that the nominees are willing to serve. Election of officers shall be by majority vote at the annual meeting of the Council of Academic Societies.

The procedure for selecting a Nominating Committee is quite cumbersome. It is recommended that the procedure for selecting a Nominating Committee be changed. It is further recommended that Section V, No. 1 of the Rules and Regulations be changed to read:

The Nominating Committee shall be comprised of seven members of the Council. The immediate past Chairman of the Administrative Board shall be the non-voting Chairman of the Nominating Committee. For purposes of selecting a Nominating Committee, six individuals shall be chosen from among the representatives present at the Annual Fall Meeting of the Council by a majority vote of the representatives present at that meeting. The Officers of the Council and its representatives to the Executive Council of the Association of American Medical Colleges are eligible to serve on the Nominating Committee with the exception of the Chairman-Elect. No Society may be represented on the Nominating Committee by more than one person. The Nominating Committee shall meet

in person to select a slate of Officers prior to June 1st of the year of the election. In the event of a tie vote, the Chairman of the Nominating Committee shall break the tie with a vote.

The Nominating Committee shall nominate not more than two individuals for each office. The committee will also recommend nominees for AAMC offices.

III. Action Items:

3. Establish 35 voting members for Assembly.

MEMBER SOCIETIES BY DISCIPLINE

ALLERGY

- *American Academy of Allergy

ANATOMY

- *American Association of Anatomists
- *Association of Anatomy Chairmen

ANESTHESIOLOGY

- *Association of University Anesthetists
- *Society of Academic Anesthesia Chairmen, Inc.

BIOLOGICAL CHEMISTS

- *American Society of Biological Chemists
- Association of Medical School Microbiology Chairmen

CLINICAL

- *Academic Clinical Lab. Physicians and Scientists
- American Federation for Clinical Research
- American Society for Clinical Investigation, Inc.
- Southern Society for Clinical Investigation

DERMATOLOGY

- *Association of Professors of Dermatology

ENDOCRINOLOGY

- Endocrine Society

GASTROENTEROLOGY

- American Gastroenterological Association

MEDICINE

- American College of Physicians
- *Association of American Physicians
- *Association of Professors of Medicine
- *Association of Teachers of Preventive Medicine
- Society of Teachers of Family Medicine

NEUROLOGY

- *American Neurological Association
- *Association of University Professors of Neurology

OBSTETRICS AND GYNECOLOGY

- American College of Obstetricians and Gynecologists
- *Association of Professors of Gynecology and Obstetrics

— *Denotes Current Voting Members in the Assembly

MEMBER SOCIETIES BY DISCIPLINE (CONT.)

OPHTHALMOLOGY AND OTOLARYNGOLOGY

- American Academy of Ophthalmology and Otolaryngology
- *Society of University Otolaryngologists
- *Association of University Professors of Ophthalmology

ORTHOPAEDICS

- *Joint Committee on Orthopaedic Research and Education Seminars

PATHOLOGY

- *American Association of Neuropathologists
- *American Association of Pathologists and Bacteriologists
- *Association of Pathology Chairmen, Inc.

PEDIATRICS

- American Academy of Pediatrics
- *American Pediatric Society
- *Association of Medical School Pediatric Dept. Chmn., Inc.
- Society for Pediatric Research

PHARMACOLOGY

- *Association for Medical School Pharmacology

PHYSIATRY

- *Association of Academic Physiatrists

PHYSIOLOGY

- *American Physiological Society
- *Association of Chairmen of Depts. of Physiology

PSYCHIATRY

- *American Association of Chmn. of Depts. of Psychiatry

RADIOLOGY

- *Association of University Radiologists
- *Society of Chairmen of Academic Radiology Departments

SURGERY

- *American Association of Neurological Surgeons
- *American Association of Plastic Surgeons
- American Association for Thoracic Surgery
- American College of Surgeons
- *American Surgical Association
- Association for Academic Surgery
- Plastic Surgery Research Council
- *Society of Surgical Chairmen
- Society of University Surgeons

UROLOGY

- *Society of University Urologists

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IV. Discussion Items:

1. Program of Fall Meeting

	S 11/4	M 11/5	T 11/6	W 11/7	Th 11/8
AM	CAS Bus. Session	Plenary	Plenary	Council Program	Misc.
PM	CAS Gen. Session	AAMC Councils' Business CAS Prog.	<u>Assembly</u> Minority Affairs	Misc.	Misc.

CAS Business Session - Sunday, November 4, 10:00 a.m. - 12 N

CAS General Session - Sunday, November 4, 1:30 - 5:00 p.m.

CAS Symposium on Ethics of Biomedical Research, Monday,
November 5, 2:00 p.m. - 5:00 p.m.

PROPOSED PROGRAM ON CERTAIN ETHICAL ASPECTS OF BIOMEDICAL
RESEARCH

CHAIRMAN: Robert G. Petersdorf, M.D.

1. A discussion of the dilemma created when rigid review, excessive regulation and miles of red tape satisfy the public but make clinical research extremely difficult to carry out such that investigators find it easier to classify their work as patient care. Thomas C. Chalmers, M.D., Director, Clinical Center, NIH.
2. Non-beneficial research on children. A discussion of the need for and the unique ethical problems created by clinical research in children, pregnant women, fetuses and abortuses. Charles Lowe, M.D., Scientific Director, National Institute of Child Health and Human Development or Sidney Blumenthal, M.D., University of Miami.
3. The problem of long-term unanticipated consequences of research. Is there a need for long-term follow-up? If so, how should this best be accomplished and who should pay for it? Jay Katz, M.D., Yale University School of Medicine.
4. Compensation of the innocent victim of research. Despite all the attention that has been directed to the ethics of experimentation with human subjects, there has been little discussion of what should be done for the research subject who is injured in spite of all ethically prescribed precautions and the procurement of adequate informed consent. Donald E. Chalkley, Ph.D., National Institutes of Health.
5. Evaluation of Concepts of Ethical Standards. What was ethically acceptable in the past is not ethically acceptable today. James Toole, M.D., Bowman-Gray School of Medicine.

DRAFT REPORT

COST OF THE BIOMEDICAL RESEARCH
CONTRIBUTION TO UNDERGRADUATE MEDICAL EDUCATION

by

THE COMMITTEE ON BIOMEDICAL RESEARCH AND RESEARCH TRAINING
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Eugene Braunwald, M.D., Chairman
W. Gerald Austen, M.D.
James Eckenhoff, M.D., Sc.D
Stuart Bondurant, M.D.
Ronald W. Estabrook, Ph.D.
Melvin M. Grumbach, M.D.
Wolfgang K. Joklik, Ph.D.

Baldwin G. Lamson, M.D.
A. Brian Little, M.D.
Joseph E. Rall, M.D.
Yale Drazin
Michael F. Ball, M.D.

Research and Medical Education

Medicine is concerned with the application of a rapidly changing body of knowledge and technology to the problems of health and disease. Consequently, its students must have a direct encounter with the scientific processes involved and the current state of knowledge in the biomedical sciences. The exponential rate at which medical knowledge has grown in the recent past, and the likelihood that it will continue to expand at the same rate in the future make it imperative that the physician be able to evaluate for himself the results of scientific investigation and have the ability to discern their usefulness in application. To develop these characteristics in the physician, medical education must encompass the opportunity for the medical student to engage with exemplary faculty in the use of the scientific method and investigative processes in the discovery of new knowledge. This can only be accomplished by a faculty that is intimately involved, in adequate measure, with the development of knowledge at the frontiers of the health sciences through their own research activities.

Medical education, therefore, necessarily encompasses an intrinsic body of research activity by virtue of the nature of its subject matter, the function of medicine, and the requisite qualifications of a physician. Such a body of research is a minimum requirement within every medical educational program and should be financed as a basic expense of medical education. It is this basic activity which provides the platform of scientific capability that enables academic medical centers to participate in and contribute to broad national research programs directed to the advancement of specific scientific fields or in the solution of specific problems. Determinations in respect to the latter, however, transcend institutional judgments and relate to national priorities and objectives. These determinations, however, must not operate to either ignore or warp the essential underlying structure of research essential to the educational process.

The Task Force on Biomedical Research began its deliberations in late 1971 and developed three broad guidelines. The Task Force agreed that:

- a. A specific range of research must be maintained at each medical school to serve the educational process. This research should be broad-based to include all departments.
- b. A second level of research among the medical schools is necessary to carry out the national policy for scientific research which can be best accomplished in a medical center.
- c. An additional level of research must be available at the medical centers to conquer specific diseases which afflict the citizenry.

Several hypothetical models were developed to try to quantify the cost of part "a" and have been applied to the eight matched schools which have formed the basis for an indepth study of the cost of medical education. The four pairs of schools were:

1. Duke University School of Medicine - Case Western Reserve School of Medicine
2. Georgetown University School of Medicine - Saint Louis University School of Medicine
3. The University of Kansas School of Medicine - The State University of New York Upstate Medical Center in Syracuse
4. The University of Iowa College of Medicine - The University of Washington School of Medicine

Following careful evaluation, the Committee elected to discard the more complex mathematical models which had been suggested and to base the cost of the contribution of biomedical research to medical education on certain arbitrary judgements. The Committee concluded that "EVERY MEDICAL SCHOOL FACULTY MEMBER SHOULD SPEND A MINIMUM OF 20% OF HIS TOTAL FACULTY EFFORT IN SCHOLARLY ACTIVITIES SUCH AS BIOMEDICAL RESEARCH. THE COST OF ONE HALF OF THIS EFFORT SHOULD BE ASSIGNED AS A COST OF UNDERGRADUATE MEDICAL EDUCATION AND THE COST OF ONE HALF OF THE FACULTY EFFORT IN BIOMEDICAL RESEARCH SHOULD BE ASSIGNED AS A COST OF GRADUATE MEDICAL EDUCATION SINCE RESEARCH IS AN ESSENTIAL COMPONENT OF BOTH OF THESE EDUCATIONAL PROCESSES.

The research costs of an institution are not incurred equally by all faculty. To more accurately assign research costs to that portion of the faculty which conducts research, the Committee evolved the concept of 'research cost per full-time investigator.' This figure is derived by multiplying the percent effort devoted to research by the number of medical school faculty to determine the number of theoretical full-time equivalents of faculty devoting their time 100% to research. This number is divided into the total research cost for the school to determine the cost of one full-time investigator conducting research. This figure includes the costs of salary, technical support, supplies, instrumentation, etc.

$$\frac{\text{Research cost}}{\text{aggregate \% effort in research} \times \text{number of faculty}} = \frac{\text{Research cost}}{\text{number of FTE researchers}} = \text{Research cost per full-time investigator}$$

The research cost/FTE investigator ranged from \$84,400 at school A to \$52,300 at school G. The reasons for the marked differences in these costs is not readily apparent from the data provided. For example, faculty salaries comprised 27% of the research cost at school D and comprised 39% of the research cost at school A, both schools with the highest research cost per FTE investigator.

The Committee assigned 10% of the cost of one full-time investigator conducting research as that cost of biomedical research which should be assigned as a cost of medical education. This figure is calculated by multiplying one half day per week, or 10% effort, times the research cost per FTE investigator. The result is then multiplied by the number of faculty to calculate the total cost of the research contribution to medical education at the institution and divided by the number of students to express the cost in that framework of reference. In each instance, the cost of the research contribution to medical education comprises less than 1/3 of the research cost of the institution and ranged from 19 to 32 % in the eight schools studied.

COST OF THE BIOMEDICAL RESEARCH
CONTRIBUTION TO UNDERGRADUATE MEDICAL EDUCATION

	DUKE	CASE	KANSAS	SYRACUSE	GEORGETOWN	ST LOUIS	U. WASH	IOWA
1. NUMBER OF STUDENTS,	338	364	487	402	473	484	392	595
2. NUMBER OF FACULTY	346	525	204	155	215	174	616	363
3. AGGREGATE % EFFORT								
TEACHING	10.0	12.3	16.4	23.9	19.9	22.9	8.3	14.3
RESEARCH	38.0	42.0	42.0	37.0	30.0	50.0	45.0	36.0
PATIENT CARE	26.0	23.0	14.0	25.0	21.0	16.0	14.0	20.0
4. RESEARCH COST (M\$)	11.1	13.3	6.3	4.5	3.4	5.7	14.5	9.5
5. % FACULTY SALARIES	38.6	35.1	33.3	27.1	42.3	35.9	33.8	31.0
6. RESEARCH COST/FTE INVEST. (THOUS.)	84.4	60.5	73.2	78.9	52.7	65.5	52.3	73.1
7. ONE DAY WEEK/RESEARCH COST/STUDENT	8,642	8,700	3,080	3,025	2,395	2,355	8,218	4,435
8. TOTAL COST OF RESEARCH CONTRIBUTION TO MED. EDUCATION (M\$)	2.9	3.2	1.5	1.2	1.1	1.1	3.2	2.7

May 17, 1973

IV. Discussion Items:

7. Invitations to individual members of the societies meeting with the AAMC to attend the CAS Fall Meeting.

	<u># of People</u>
Association of Academic Physiatrists	20
Society of University Urologists	100
Society of University Otolaryngologists	100
Association of Professors of Medicine	100
Society of Teachers of Family Medicine	200
Association of Orthopaedic Chairmen (not member, but will be in November)	130
Association of Chmn. of Depts. of Psychiatry	100
Association of Anatomy Chairmen	100
Association of Pathology Chairmen, Inc.	70
Association of Chairmen of Depts. of Physiology	60
Assn. of University Professors of Ophthalmology (Meeting at Mayflower Hotel)	100

V. Information Items:

2. Council of Deans' resolution on the need for a strategic planning effort.

The Council of Deans recommends that the Executive Council direct the revision and expansion of the paper entitled, "Medical Education, the Institution, Characteristics and Program - A Background Paper", to include a discussion of the issues presented and the development of a potential long-range strategy for approaching their solution; such a paper to take the form of a "green paper" for discussion and review by the Executive Council, the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals and ultimate adoption by the AAMC Assembly.

3. CAS Nominating Committee 1973-74.

The CAS Nominating Committee met on June 6, 1973 in Washington, D.C. A report will be given at the Administrative Board meeting. A list of the Committee appears on the next page.

CAS NOMINATING COMMITTEE
1973 - 74

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(202) 466-4663

Connie Choate
Secretary to
August G. Swanson, M.D.
(202) 466-5194

V. Information Items, continued

4. Current status of the efforts to develop a telephone network with selected societies

Several societies have expressed an interest in setting up a telephone cascade. The following is a proposed guideline for establishing such a cascade:

One of the major challenges facing us as we try to effect evolution of biomedical research policy is how to best utilize energies of our constituents. Gus Swanson and I have been discussing this matter for some time and would like to suggest that the (name of society) consider developing a telephone cascade which we could trigger on key legislative issues. We would anticipate using this system about ten times each year.

The system would work in the following manner:

Gus or I would telephone the office of a person you designate and provide the basic information to be transmitted. This individual would then call five designated persons and relay the information. Each of these five individuals would then call five additional persons, etc. Mathematically, if every one cooperated, four series of telephone calls would reach 656 people and five series would reach 3,156 people. We would plan to provide you a succinct summary of the key material which could be dictated to a secretary and thus avoid the word-of-mouth "garble" phenomenon.

Each person who agrees to participate in this cascade would have two responsibilities. First, to begin to develop a liaison with his own Congressman and Senators such that his views would be respected by the legislators; and secondly, to telephone the designated five people.

We also will need some mechanism to evaluate the effectiveness of your cascade. In this regard, I would propose that certain people in your organization be placed at the final level in the system and requested to mail the message received back to this office.

The major flaw in the proposed system is the human element. Members of your cascade who do not fulfill their responsibilities sabotage the system. In order to circumvent some of the uncontrollables, like travel, committee meetings, teaching assignments, etc., I propose to use secretaries as much as possible. For example, my secretary could call your secretary and dictate the information. Your secretary would transcribe one copy of the information for you and then call the secretaries of the five people on your list without waiting for your approval. Thus, information could be relayed

through the system quickly. It is conceivable, utilizing secretaries, that the message could be transmitted through the whole system in less than an hour.

I shall be interested in your response to this suggestion.

5. Proposed guideline on "How do I talk to my Congressman"

Increased federal activity and increased federal spending have resulted in increased legislative activity among special interest groups. In view of these trends, many interests which seldom bothered to exert pressure on Congress in the past have found it necessary or advantageous to do so. Biomedical scientists, in particular, have been reluctant to solicit the support of the legislature or to call attention to the implications of legislative decisions for medical education and biomedical research.

Special interest groups perform a number of important and indispensable functions in their contacts with members of Congress. Such functions include helping to inform both the Congress and the public about problems and issues, stimulating public debate, opening a path to Congress for the wronged and needy, making known to Congress the practical aspects of proposed legislation--who it would help, who it would hurt, who is for it and who is against it. The spinoff from this process is considerable technical information produced by research on legislative proposals.

Most legislators do not solicit views directly, but rather rely on their constituents to keep them informed. To paraphrase the old adage, "the squeaky wheel gets the oil" or in this case, the legislator's ear. Most Congressmen and Senators maintain two offices, one in Washington and a second in their home district. Most Congressmen spend Tuesday, Wednesday and Thursday in Washington and are available in their district offices on Monday and Friday. In addition, during Congressional recesses, legislators spend a greater period of time at their regional offices.

Four possible methods of contacting members of Congress are suggested:

A. A personal visit. By far the best method. Call and make an appointment. Do not be disappointed if you are dealt with by a Congressional aide or assistant. An aide often exerts important influence on the member serving as a very necessary extra set of eyes and ears.

B. A telephone call. The local office should be listed in your telephone directory or call the Capitol switchboard, (202) 224-3121, which can connect you with the office of any member of Congress.

C. A letter. The shorter the better. To a Senator, the mailing address is U.S. Senate, Washington, D.C. 20510. To a Representative, the mailing address is U.S. House of Representatives, Washington, D.C. 20515.

D. A telegram. Tell the Western Union Operator you wish to send a personal opinion message of less than 15 words, not counting name and address.

The most important aspect of communicating with legislators is transmitting the idea that you are interested in being certain that the legislator understands the implications of various legislative issues for their district. Do not assume specialized knowledge on the part of the Congressman, regardless of his background or position, unless you personally know the man and are confident of his thorough understanding of medical education or biomedical research. Make your presentation succinct and illustrate it with specific references to your institution and the local situation.

A one shot visit may accomplish little and it may take three or four visits before the legislator begins to recognize that you can be of help to him. It is important to follow up votes which are in accord with your point of view with recognition and approval and to inquire why, when the legislator's vote is in disagreement with your point of view.

Your society is a participant in the Council of Academic Societies of the Association of American Medical Colleges. The staff of the AAMC at One Dupont Circle can frequently provide up-to-date information as to the status of various legislative proposals. As an initial point of contact, you may wish to call upon Michael F. Ball, M.D., (202) 466-5152 or Rosemary Wilson, (202) 466-5187.

APR 10 1973



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21205

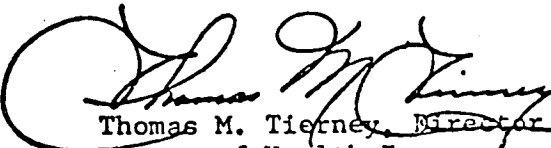
PART
B

March 1973

INTERMEDIARY MANUAL
REVISION TRANSMITTAL NO. 320

<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Sec. 6102.6-6102.8	21-21.1 (2 pp.)	21-21.1 (2 pp.)

Section 6102.7, Interns and Residents, has been revised to include within the definition of "physicians' services" services performed by interns and residents outside their regular training program in a hospital other than the hospital in which they are in training under such program provided that they are fully licensed to practice medicine in the State in which the services are rendered and are not compensated by a provider. Any services rendered in the hospital with the approved teaching program under which the interns or residents are in training continue to be reimbursable, if at all, only as provider services. This policy is effective on receipt and is applicable to claims not yet adjudicated as well as to adjudicated claims coming to the carriers' attention. Files should not be searched, however, to locate previously denied claims.


Thomas M. Tierney, Director
Bureau of Health Insurance

Action Note: Add to the last paragraph of § 6012, "(See, however, § 6102.7B regarding circumstances under which services of certain moonlighting residents are reimbursable on a reasonable charge basis.)"

6102.6 Provider-Based Physicians' Services.--The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, etc., whether or not they bill patients directly) include two distinct elements: the patient-care component, and the provider component. (The services of interns and residents are reimbursable to the provider on a reasonable cost basis even though the intern or resident is a licensed physician.)

A. The Professional Component.--The patient-care component of provider-based physicians' services includes those services directly related to the medical care of the individual patient. (No Part B charge can be recognized for autopsy services.) When such services are performed by a faculty member of a medical, osteopathic, dental, or podiatry school billing may be by the school with the physician's authorization. See § 6330 for form and procedures for billing for services of provider-based physicians. See § A6015 for limitations on reassignment under the 1972 Amendments.

B. The Provider Component.--Provider-based physicians often perform professional services other than those directly related to the medical care of individual patients. These may involve teaching, administrative, and autopsy services, and other services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs. Reimbursement for such costs is made under Part A where they relate to inpatient services and under Part B where they relate to outpatient services and inpatient ancillary services where there are no benefits payable under Part A. (See § 6852.2 on distinguishing between professional and provider components for reimbursable purpose.)

C. The Roles of the Fiscal Intermediary and Carrier.--The provider's Part A intermediary will obtain from the provider information it and the Part B carrier need to make payment determinations where the services of provider-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between provider and physician on the allocation of physician compensation (received from or through the provider) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the provider and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue (§ 6852.6). The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of provider-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, the uniform percentage if the optional method of determination is used, or the unit charge if the per diem or per visit method is used (§§ 6856ff.).

Group practice prepayment plans which deal directly with the Social Security Administration may make a written agreement with a hospital, or with physicians in a hospital, to reimburse the professional component of the hospital-based physician's charge for services to plan-members entitled to Part B. These claims will not be processed by carriers.

6102.7 Interns and Residents.--

A. General.--For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting (e.g., unlicensed graduates of foreign medical schools). As a general rule, services of interns and residents are reimbursed on a reasonable cost basis by the Part A intermediary. However, the services of an intern or resident are reimbursable by the carrier on a reasonable charge basis as physicians' services where the individual: (1) renders the services off provider premises (however, see also B below, regarding certain "moonlighting" interns and residents); (2) is not compensated by a provider; and (3) is fully licensed to practice medicine by the State in which the services are performed. (See §§ 6704.5 and 6806 regarding the reasonable charge determination.)

See §§ 3101.6 and 3115 of the Part A Intermediary Manual (HIM-13) regarding approved programs and coverage as a provider service under hospital and medical insurance.

B. "Moonlighting" Interns and Residents.--Services a moonlighting intern or resident performs in the outpatient department or emergency room of the hospital which has the training program in which he is participating are reimbursable only on a Part B reasonable cost basis (i.e., all services performed in the hospital with the training program are treated as part of the training program). In addition, any services a "moonlighting" intern or resident furnishes in the hospital other than the one with the approved training program under which the intern or resident is in training are reimbursable on a Part B reasonable cost basis if he is paid for such services on a salary or other fixed compensation basis by the hospital in which such services are rendered (or by another hospital). However, such services are reimbursable by the carrier on a reasonable charge basis as physicians' services if the intern or resident is not so compensated and if he is fully licensed to practice medicine in the State in which the services are performed.

6102.8 Supervising Physicians in the Teaching Setting.--Medical insurance covers the services attending physicians (other than interns and residents) render in the teaching setting to individual patients.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

Retain - 6 mos.

1 yr.

5 yrs.

Permanently
Follow-up Date

DATE June 1, 1973

TO: CAS Administrative Board
FROM: Connie Choate, Secretary to August G. Swanson, M.D.
SUBJECT: Next Meeting

The next meeting of the CAS Administrative Board is scheduled for:

Thursday, June 21, 1973
1 Dupont Circle, N.W.
Room 827, 8th Floor
Washington, D. C.
9:30 a.m. - 4:00 p.m.

The agenda will be mailed shortly.

Please indicate on the attached form whether or not you will attend the Board meeting and if you will need a hotel room for June 20. Hotel rooms will be booked at the Embassy Row.

THERE WILL BE NO DINNER MEETING THE EVENING OF JUNE 20.

Thank you.

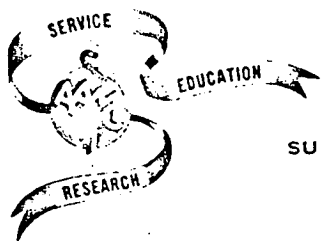
CC/sd
Enclosure

Robert G. Petersdorf, M.D.
Ronald W. Estabrook, Ph.D.
William B. Weil, Jr., M.D.
Robert M. Blizzard, M.D.
David R. Challoner, M.D.
Ludwig Eichna, M.D.

Robert E. Forster II, M.D.
Charles Gregory, M.D.
Rolla B. Hill, Jr., M.D.
Sam L. Clark, Jr., M.D.
Ernst Knobil, Ph.D.

cc: AAMC Executive Staff

COPIES TO:



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

PLEASE COMPLETE THIS FORM AND RETURN TO CONNIE CHOATE AS
SOON AS POSSIBLE.

I will ____ will not ____ attend the CAS Administrative Board
meeting on June 21, 1973.

I do ____ do not ____ wish a hotel room for June 20.

Signed _____

Date _____

ROLE OF OSR AND GSA REPRESENTATIVES IN MONITORING PROCEDURES
OF THE NATIONAL INTERN AND RESIDENT MATCHING PROGRAM (NIRMP)Background

At its business meeting in November 1972, the AAMC Group on Student Affairs (GSA) adopted a resolution urging that the National Intern and Resident Matching Program (NIRMP) improve its enforcement of the "all or none" principle for hospital participation in the program. Similarly, at its November business meeting, the AAMC Organization of Student Representatives (OSR) adopted a resolution to establish a system of investigating NIRMP violations and reporting them to appropriate authorities.

In response to these actions, staff of the Division of Student Affairs developed a proposal for the role of OSR and GSA representatives in monitoring the procedures of NIRMP. This staff proposal was approved in principle by Western OSR and GSA members at their regional meeting in Asilomar, California, in March.

The program outlined below, which is a modification of the original staff proposal, was drafted and approved by the Southern region of OSR at its meeting in Williamsburg in April. This program was subsequently supported in principle by Southern GSA at the same meeting.

The basic elements of the Southern region's NIRMP monitoring program were also approved by the Central region of OSR at its meeting in Starved Rock, Illinois, in May. Just prior to this meeting, the NIRMP Board of Directors had agreed that one of its three student members could be appointed by the OSR Administrative Board, so the Central region version of these procedures included the concept that the OSR National NIRMP Monitor would also be a member of the NIRMP Board. Central region OSR also suggested that the Coordinating Council for Graduate Medical Education be included among the recipients of violation reports in lieu of the AAMC Executive Committee and developed a procedure under which CCGME could eventually deny accreditation to any institution of graduate medical education having a program found to be in repeated violation of NIRMP rules. Central GSA approved the Central OSR version of the basic monitoring program but did not act on those portions of the Central OSR proposal concerning accreditation.

It is presently planned that AAMC will assume all staffing responsibility for the functions of the OSR National NIRMP Monitor. Reports of violations will be sent to the Monitor at AAMC Headquarters and AAMC staff will conduct correspondence and take action as appropriate in his/her name, with copies of all materials forwarded to the Monitor.

At its meeting on June 8, the OSR Administrative Board expects to develop a final proposal for OSR monitoring of NIRMP violations, based on the versions approved by OSR and GSA in the three regions which have met this spring, and to select an OSR National NIRMP Monitor for the coming year. Assuming Executive Council approval of this program, the final proposal and the name of the Monitor would be promptly circulated to GSA and OSR members, so implementation of the OSR role in monitoring NIRMP violations may begin this summer.

Program

(1) The role of the AAMC Organization of Student Representatives and Group on Student Affairs in assisting in the maintenance of the NIRMP should be mainly one of channeling student reports of non-compliance to a committee established to review such problems by the dean of each medical school.

(2) The membership of this committee shall include a representative of the OSR and of the GSA as well as any other members appointed by the dean.

(3) When the NIRMP is explained to the rising seniors, the importance of working within established procedures should be stressed to them by this committee. Students shall be asked to report to any member of this committee evidence of any internship or first-year graduate program trying to seek contract agreements outside of the established arrangement for matching.

(4) The committee shall (a) guarantee anonymity to a complaining student, and (b) be responsible for securing all pertinent data in a form pre-established by the complaint review committee. As necessary, any committee member may request a meeting of the committee to determine whether data submitted merit follow-up. If it is agreed that violations exist and that the hospital program in question does not intend to abide by its contract agreements, the committee will (a) advise the dean, and (b) report the violating hospital and department to the OSR National NIRMP Monitor.

(5) The OSR Monitor shall send a report of such violations to the NIRMP Board of Directors and to the AAMC Executive Committee. This report shall state only that X number of various types of violations have been reported concerning Institution Y, Department Z. The Monitor will request that NIRMP acknowledge receipt of such reports and advise him that appropriate action will be taken. It shall then be up to the NIRMP to see that prompt appropriate action is taken by them and/or by the AAMC Executive Committee as needed.

(6) If the National Monitor has reason to believe that appropriate action on a reported violation is not being taken by NIRMP, the Monitor may at his discretion resubmit the report in question to the NIRMP Board of Directors, indicating that this is a second notice.

(7) The National Monitor shall determine, by the time of the AAMC annual meeting, whether (a) all reports of violations forwarded to the NIRMP Board of Directors and AAMC Executive Committee have been received, and (b) the NIRMP has taken action on them. The Monitor shall report these results at the OSR annual meeting.

(8) The OSR Monitor shall be selected by a majority vote of the OSR Administrative Board during the annual meeting. Assuming agreement with this procedure by the Central and Northeast GSA and OSR at their 1973 regional meetings, a temporary National Monitor will be appointed by the OSR national chairman to serve until the 1973 OSR annual meeting.

(9) This procedure shall be reviewed every three years.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

[Agenda
Addition]

INTER-OFFICE MEMO

Retain - 6 mos.

1 yr.

5 yrs.

Permanently
Follow-up Date

DATE June 14, 1973

TO: CAS Administrative Board

FROM: August G. Swanson, M.D.

SUBJECT: Additional Information Item for CAS Administrative
Board Meeting Agenda, June 21, 1973.

The attached material is the report of the LCME
which will be submitted to the Executive Council.

AGS/sd
Enclosure

Robert G. Petersdorf, M.D.
Ronald W. Estabrook, Ph.D.
William B. Weil, Jr., M.D.
Robert M. Blizzard, M.D.
David R. Challoner, M.D.
Ludwig Eichna, M.D.

Robert E. Forster II, M.D.
Charles Gregory, M.D.
Rolla B. Hill, Jr., M.D.
Sam L. Clark, Jr., M.D.
Ernst Knobil, Ph.D.

COPIES TO: AAMC Executive Staff

RATIFICATION OF LCME ACCREDITATION DECISIONS

In their wording recognizing accredited medical schools, the various state medical practice acts are not constant. Some require recognition by the Council on Medical Education of the AHA, some membership in the AAMC, some accreditation by the LCME, and some by a combination of these.

The following list of medical schools is presented to the Executive Council so that its action may be formal and within the letter of some states' laws. All of these schools have been visited, reported on; the reports have been circulated and accepted, and acted upon by the LCME on March 28, 1973.

<u>FULLY DEVELOPED SCHOOLS</u>	<u>SURVEY DATE</u>	<u>YEARS APPROVED</u>	<u>ENTERING CLASS SIZE</u>
A. Un. of Manitoba	11/72	5	100
B. Stritch, Loyola Un.	9/72	7 (biennial Progress reports	130
C. Temple Un.	11/72	7 (Progress Report, Dec. '73)	180
D. Wayne State	12/72	5 (Progress Report 1974)	256
E. Un. North Carolina - (East Carolina)	1/73	7*	

*On motion, seconded and carried, the LCME conferred full accreditation for a period of seven years from the date of the Survey.

The entering class (including any students enrolled in affiliated programs in East Carolina or elsewhere) will continue at 130 through 1974-75. The 1975-76 entering class would be increased to 140 and in 1976-77 it would be further increased to 160. *** These increases are predicated upon two capital projects, the renovation of the MacNider Building and the new Laboratory-Office Building. The two facilities, plus some additional renovations which could not exceed \$1 million in the period 1973-80 will be adequate for the further projected increase to four classes of 160 each.

The LCME also recommends 1) that a Progress Report be submitted not later than January 1, 1974 outlining the steps which have been taken to assure the quality of the program at the East Carolina University School of Medicine, and 2) that the LCME be advised of the outcome of the studies being undertaken by the Board of Governors of the University of North Carolina relative to the East Carolina program of medical education so that a further determination can be made relative to its accreditation status.

It further recommends that the enrollment of students at East Carolina University School of Medicine be limited to 20.

RECOMMENDATION: The Executive Council approve as accredited the list of schools for the terms stated and their continued membership in the Association.

JUN 4 1973

ACCREDITATION SURVEYS, DEVELOPING MEDICAL SCHOOLS

- A. SUNY-Stony Brook 12/72 Continued provisional approval
(first M.D.'s, June 1974)
- B. Un. of Missouri, Kansas City 12/72*

*The LCME conferred full accreditation for a period of two years, beginning 13 December 1972, for a class limited to 40 in Year III, with no transfers to Years IV, V and VI, at least until the next Survey. Though Years I and II are not within the authority of the LCME, it is advised that students in Years I and II be advised of their pre-medical (provisional medical student) status.

The Dean is requested to submit, on 1 January 1974, an interim Report of Progress on the items of concern and specific recommendations contained in the Report of the Survey. Further affirmative action on accreditation by the LCME depends upon affirmative action by the school in matters of docent recruitment and in education in the basic sciences.

RECOMMENDATION: That the Executive Council ratify the above actions of the LCME.

SPECIAL SURVEYS, MANDATED BY LCME

- A. Eastern Virginia Medical School February 1973 - The LCME reaffirmed the decision to deny the request to enroll a charter class in September, 1973. (The original decision was taken on January 10, 1973.)
- B. Louisiana State University School of Medicine - The LCME placed Louisiana State University School of Medicine, New Orleans on Open Probation, effective November 18, 1972, until positive evidence is produced that solutions are forthcoming for a number of deficiencies outlined in the report of the 1970 visit as well as in the report of the current visit.

The Secretary was instructed to transmit this action for ratification to the Council on Medical Education of the AMA and to the Executive Council of the AAMC.

RECOMMENDATION: That the Executive Council ratify the action of the Liaison Committee on Medical Education to place Louisiana State University, New Orleans School of Medicine on probation.

Letter of transmittal to the Chief Executive Officer of the University follows:

April 13, 1973

William H. Stewart, M.D.
Chancellor of the Medical Center
Louisiana State University
School of Medicine
1542 Tulane Avenue
New Orleans, Louisiana 70112

Dear Dr. Stewart:

This letter is to advise you of the action of the Liaison Committee on Medical Education and to transmit formally the report of the survey team representing it, which visited the Louisiana State University School of Medicine, New Orleans, on November 15-18, 1972. As you know, the Liaison Committee represents the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. The purpose of the visit was to evaluate and consider the accreditation of the program in undergraduate medical education.

This decision by the Liaison Committee to confer the status of Probation on LSU - New Orleans School of Medicine will be transmitted for consideration and ratification to the Council on Medical Education, American Medical Association and the Executive Council, Association of American Medical Colleges. A final decision may be expected from these two bodies by 1 July, 1973. You will be informed of the final result.

The survey team also recommends that the Louisiana State University School of Medicine in New Orleans maintain continued institutional membership in the Association of American Medical Colleges.

A copy of the Survey Report is being sent to John A. Hunter, Ph.D., President of the Louisiana State University and to Norman C. Nelson, M.D., Dean of the Louisiana State University School of Medicine, New Orleans. If you have any questions about the report or its uses, I should be glad to have you contact me.

The report is considered confidential by the Liaison Committee and by its parent organizations. However, it is for the use of the University and the Medical School as dictated by the best judgment of its officials.

Initiative rests with the School of Medicine, LSU - New Orleans, as regards removal from the category of Probation. Achievement of substantive solutions to the list of problems cited above should be reported periodically to the Secretary, Liaison Committee on Medical Education. A further official survey by a team from the LCME may be requested by LSU - New Orleans School of Medicine when improvements in the situation appear to justify a review of the status of Probation. In absence of such a request, the LCME may hold a limited revisit to assess the status of the school by November, 1974.

Page 2

Should questions arise regarding these findings and decisions taken by the LCME, I should be glad for you to contact me.

Sincerely,

Marjorie P. Wilson, M.D.
Secretary
Liaison Committee on Medical
Education

MPW/rbo

ccL John A. Hunter, Ph.D.
Norman C. Nelson, M.D.
Glen R. Leymaster, M.D.

LCME PROCEDURE FOR DEVELOPMENT OF A NEW MEDICAL SCHOOL; PRE-ACCREDITATION STATUS

The LCME has refined its procedures for surveillance on newly developing medical schools. The following document defines LCME staff consultation, functions, LCME preliminary survey visits, the pre-accreditation survey and a new system of evaluation of components of the proposed school, to involve LCME members as well as members of its parent Councils. (Executive Council of the AAMC and the Council on Medical Education of the AMA).

RECOMMENDATION: That the Executive Council endorse the adoption of this procedure.

INFORMATION ITEM

In addition to the development of the procedures indicated in the following document, the LCME adopted the following clarification of LCME policy for assessment of newly developing medical schools -

"While there is a need for continuous experimentation in the process of medical education, it should be understood by the developers of new programs that recent experience (since 1960) in the emerging schools indicates the desirability of the following:

- 1) a critical mass of competent and nationally qualified basic scientists to staff the basic science disciplines,
- 2) a critical mass of competent and nationally qualified full-time clinicians to staff the principal clinical disciplines, and
- 3) a governance mechanism which allows these people a voice in the development of educational policy."

LIAISON COMMITTEE ON MEDICAL EDUCATION

POLICIES AND PROCEDURES FOR DEVELOPMENT OF A NEW MEDICAL SCHOOL;
PRE-ACCREDITATION STATUS*

1. Staff Discussion Stage --

- A. Letters and telephone calls to LCME staff officers from proponents and advocates --

Early
Reference
Packet

-- staff sends descriptive materials: enters name on list of possible new schools.

1. LCME description - RCA document -
2. "Information to be Submitted by Developing Medical Schools"
3. "Functions and Structure", appendices -
4. This document (public version)
5. Policy Statement; "Interrelationship of Basic and Clinical Sciences"

- B. Visits by proponents to one or more parent association staff offices --

Detailed
References

-- Staff explains the process of achieving accreditation -- interprets need for quantity and quality of essential ingredients for a new school.

-- A series of visits involving different people may occur.

-- Staff should record a brief summary of the dialogue occurring during primary visits and enter this information periodically into a quarterly agenda of the LCME.

-- Staff should provide additional specific reference materials; should respond formally to a request for nomination of reputable consultants.

- C. Staff visit to site of a proposed new medical school --

-- This type of visit may be initiated by the Secretary and Senior Staff officers, or by the LCME.

Staff
Visit

-- Only Senior Staff members with broad experience in medical education and institutional management should be assigned this significant chore which often requires discretion, tact, and diplomacy, yet capacity for forceful expression about the need for quality in medical education to interviewees who may include the governor, legislative committees, chancellors of state systems of higher education, university presidents, etc.

-- a report of a staff visit must be presented to the LCME and acted upon by that body.

* Adopted by the LCME, January 10, 1973.

2. Consultation Stage -- may be initiated by Staff or by LCME

A. Before appointment of the Dean --

Member-Staff
Consultation
Visit

-- When the new project acquires an official sponsoring agency, preferably a university; and when there is visible prospect of financial support such as an appropriation for a feasibility-planning study by a state legislature, the LCME and staff should provide a formal consultation visit of one or two days' duration, employing one or more members and one or more Senior Staff officers.

-- When conducting these consultations, the site visitors should advise the institution about collection of the spectrum of data needed by the LCME to make an adequate judgment about pre-accreditation and issuance of an official Letter of Reasonable Assurance of Accreditation. Such data are listed in the LCME document "Information to be Submitted by Developing Medical Schools," and in the usual pre-survey questionnaire material.

-- The staff should furnish accurate, current data about experience with annual operating costs of medical schools, start up costs, and capital development costs of new schools established recently. Such data should be developed by staff using LCME annual questionnaires and pre-survey information. Preferably such studies should be published periodically for general reference.

-- The staff consultants should report to the LCME the general details of their observations during the visit and should enumerate the visible assets and deficiencies relative to development of the new school.

B. After appointment of the Dean --

-- After the LCME has reviewed the report of the consultation visit and has received notice of the appointment of a Dean, the institution can then be designated a Developing Medical School.

-- Following the appointment of the Dean, the school will need a period of months to a year or more for accomplishment of early planning of facilities, recruitment of a nucleus of faculty, acquisition of necessary financial resources, mobilization of community resources, etc. The Dean should avail himself of consultation available from Senior Staff, particularly those who made the consultation on site. It would be expected that the Dean would make periodic visits to the offices of the parent councils to obtain this service and to report progress.

-- The next stage, the Pre-Accreditation Survey, should not be scheduled until the Dean has convinced the LCME that substantive progress has been achieved.

-- On the basis of the information available about a proposed new project in medical education, the LCME may require that this consultation visit (stage 2) be held first or be waived in favor of direct progression to Stage 3. Pre-Accreditation Survey.

3. Pre-Accreditation Survey -- a fee should be charged.

Experience has indicated that this step in the development of a new medical school is the most significant of all. Pre-Accreditation status should not be granted, nor should a Letter of Reasonable Assurance of Accreditation be issued until the members of the LCME have been satisfied that the new program has fool-proof prospects for successful development.

Formal Pre-
Accreditation
Survey

Because of the importance of this decision by LCME, the staff must arrange and require that the proposed school under study produce a careful documentation of its constellation of necessary ingredients. After staff has received the indicated pre-survey material and reviewed it for completeness and accuracy, a survey team should be assembled for a careful site visit.

In this type of site visit a Senior Staff person should serve as the organizing Executive Secretary, perhaps even assisted by a more junior staff secretary drawn from parent organizations.

The Chairman should be an experienced member of prior survey teams and preferably a member of the LCME. The remainder of the team should represent basic scientific and clinical disciplines and perhaps hospital management as well.

The duration of the visit should be adjusted to meet the needs of a complete, thorough survey. It might be desirable for the Secretary to arrive on site a day or so in advance of the full team so as to oversee detailed arrangements for the visit.

The Survey Report and its very significant recommendations should be prepared by the staff Secretary and circulated to the team members for correction and/or modification as indicated. The report should contain accurate factual descriptive data on all significant components of the proposed school. Following its acceptance by the team, the report should be circulated to parent council reviewers.

A special vote form should be used in determining pre-accreditation status, with the team members and parent councils' evaluators being asked to render judgments not only on the customary general matter of approval of the project, but also to render judgments as to the adequacy of the components listed on the "Quality Rating Sheet" which follows.

The rating sheet requests the evaluators to specify, item by item, any deficiencies observed in the current and projected status of the developing medical school. It is hoped that this attempt to quantitate the characteristics of the new proposal will improve the effectiveness of the LCME in making the determination of pre-accreditation status.

The recommendations of the Pre-Accreditation Survey team should include limitations on the size of the charter class and designation of a tentative enrollment growth plan for the first several years. Only in very unusual circumstances should approval be recommended for enrollment of students on advanced standing.

QUALITY RATING SHEET

School _____

Date of Survey _____

(Check one; write Comments on
attached pages)

	<u>Adequate</u>	<u>Marginal</u>	<u>Inadequate</u>
1. Justification for this new program of Medical Education -	_____	_____	_____
2. Commitment to the new program by its sponsors -	_____	_____	_____
3. Mobilization of Community and professional support -	_____	_____	_____
4. Financial Resources: Current operations -	_____	_____	_____
Five year projection -	_____	_____	_____
5. Physical Facilities: Basic Sciences; Students and Faculty			
A. Temporary start up -	_____	_____	_____
B. Permanent -	_____	_____	_____
Clinical Activities:			
C. Faculty offices/labs -	_____	_____	_____
D. Hospital facilities -	_____	_____	_____
E. Ambulatory care facilities -	_____	_____	_____
F. Affiliation agreements -	_____	_____	_____
Library - Learning Center:	_____	_____	_____
6. Organizational plan of the faculty -	_____	_____	_____
7. Leadership of the new school			
A. Dean and assistants -	_____	_____	_____
B. Business management -	_____	_____	_____
8. Faculty Quality (current status)			
A. Basic Sciences -	_____	_____	_____
B. Clinical Sciences -	_____	_____	_____
9. Projections for full faculty growth -	_____	_____	_____
10. Proposed plan of curriculum -	_____	_____	_____
Plans for evaluation -	_____	_____	_____

Quality Rating Sheet
Page 2

School _____

Date of Survey _____

	<u>Adequate</u>	<u>Marginal</u>	<u>Inadequate</u>
11. Pool of qualified students -	_____	_____	_____
12. Plans for student guidance and academic counseling	_____	_____	_____
13. Student evaluation	_____	_____	_____

Summary Evaluation:

1. Pre-accreditation status and a Letter of Reasonable Assurance of Accreditation should be granted. _____
2. This school is not yet ready for pre-accreditation approval; the deficiencies are listed on the attached pages. _____

Signed: _____

Date: _____

Date of Survey _____

Comments: _____

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

LIAISON COMMITTEE ON MEDICAL EDUCATION: APPEALS PROCEDURE

The attached document will have been considered by the Liaison Committee on ~~Med~~ical Education at its June 13, 1973 meeting. It represents a second version of an appeals procedure previously considered by the LCME and revised in accordance with the LCME directions. It is anticipated that the document will be adopted by the LCME in substantially its present form.

RECOMMENDATION: That the Executive Council endorse the LCME appeals procedure as adopted by that Committee.

PROCEDURE FOR THE APPEAL OF AN ACTION
OF THE LIAISON COMMITTEE
ON MEDICAL EDUCATION*

1. Any action by the Liaison Committee on Medical Education which constitutes an adverse action with respect to the school or program shall entitle the school to notification of such action by registered mail return receipt requested.
2. In each such case, the school or program shall have a period of thirty days after receipt of such notification to request an informal review before the adverse action becomes the final action of the Liaison Committee.
3. When an informal review is requested the Chairman of the Liaison Committee will appoint the subcommittee from the LCME membership consisting of one representative of each of the parent councils, and one public or federal member. One of these persons shall be designated as chairman.
4. This subcommittee shall review all the material relevant to the accreditation decision, including the presurvey material, the self-study, the survey team report, the critique of the report by the dean, the votes and comments of each reviewer of the survey team report, and such other material as may be submitted by the school in support of its contention that the adverse decision should be rescinded. On motion of the subcommittee or the school, a representative of the school may meet with the subcommittee to discuss the materials and their relevance to the accreditation decision.
5. At the conclusion of its deliberations, the subcommittee shall return the case to the LCME with the summation of the matters considered and the evidence presented.
6. Upon receipt of the subcommittee report, the Liaison Committee shall reconsider its previous decision and take such action as it deems appropriate in light of the report.

*Available only in the case of adverse action. In the case of existing schools, adverse action includes only probation or disapproval, not approval for a limited term. In the case of a new school, an adverse action includes refusal to consider for accreditation, denial of the status of reasonable assurance of accreditation, and denial of provisional accreditation.

7. The Secretary of the Liaison Committee shall notify the school of the action of the Liaison Committee by registered mail, return receipt requested. If this decision is an adverse action, the school will be permitted a period of ten days from receipt of the decision to notify the Liaison Committee of its intent to appeal the action prior to public disclosure. If no such notice of intent to appeal is received, the decision will become final and subject to public disclosure.

8. The appeal must be received by the Secretary of the LCME within 30 days after the notification of the adverse decision. Although it need not follow any prescribed form, the appeal shall clearly identify the question or questions in dispute and contain a full statement of the appellants position with respect to such question or questions, as well as the pertinent facts and arguments in support of such position.

9. An appeal shall be based solely on the ground that 1) the Liaison Committee decision was arbitrary, capricious, or otherwise based on elements lying outside of the scope standards set forth in the "Function and Structure of a Medical School," or 2) not supported by substantial evidence of non-compliance with such standards.

* * * * *

APPEALS BOARD

1. Upon receipt of notice of intent to appeal an adverse decision of the Liaison Committee, the Secretary shall notify the Chairmen of this fact. The Chairman shall in turn institute the proceedings for the appointment of an Appeals Board to hear the appeal.

From a list of persons whose names have been submitted by the parent councils, and the public and federal members of the Liaison Committee, an Appeals Panel will be developed. The Appeals Panel shall consist of approximately 100 persons (or whatever number seems appropriate) judged by the Liaison Committee to be qualified by training experience and reputation to make a fair and reasoned recommendation regarding the merits of an accreditation decision.

In each case requiring such action, a 3 member Appeals Board will be appointed from members of the Appeals Panel in the following manner:

- A. One member to be named by the Chairman of the LCME;
- B. One member to be named by the institution appealing the action;
- C. The third member chosen by the first two named;
- D. One of the three shall be named Chairman of the Appeals Board by action of the Board;

Provided that no member of the Appeals Board shall currently be a member of the LCME, the parent councils, the parent association staffs, affiliated with the institution whose accreditation is under consideration, a member of the survey team whose report led to the LCME decision, or any other person who has participated in the decision-making process leading to the action being appealed.

2. Procedural Rules

- A. If, in the opinion of the appeals board, there exists no dispute as to a material fact requiring oral testimony, the appeals board shall take appropriate steps to afford the appellant, the constituent agency, or any other party to the proceeding an opportunity to present his case,
 - a. in whole or in part in writing, or
 - b. in an informal conference before the panel which shall include provisions designed to insure each party: 1) sufficient notice of the issues to be considered and 2) an opportunity to be heard.

B. With respect to cases involving the dispute as to material fact, the resolution of which would be materially assisted by oral testimony, the board shall take appropriate steps to afford to each party an opportunity for a hearing on the record which shall include provisions designed to assure each party the following:

- a. a transcript of the proceeding (to be paid for by the appellant);
- b. an opportunity to present witnesses on his behalf;
- c. an opportunity to cross examine other witnesses either orally or through written interrogatories.

3. Evidence may be received at the hearing even though of kind inadmissible under the rules of evidence applicable to court procedure.

4. The Appeals Board will consider such parts of the record as are cited or as may be necessary to resolve the issues presented. To the extent necessary, it will exercise all powers which could have been exercised if it had made the initial decision.

5. In reaching its conclusions upon the record presented, the Board may adopt, modify, or set aside the bases upon which the initial decision was rendered, and will include in its decisions and recommendations to the Liaison Committee, a statement for the reasons or basis for its decision (and any concurring or dissenting opinions).

6. In those cases where the Board believes it should have further information or additional views of the parties as to the recommendations to be rendered to the Liaison Committee, in its discretion it may withhold its final decision and recommendation pending receipt of such additional information or views.

7. Wherever possible the Liaison Committee will consider the recommendation of the Appeals Board and make its final determination at its next meeting subsequent to receipt of the report of the Appeals Board.

8. The final decision of the Liaison Committee on Medical Education is subject to ratification by the Executive Council of the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association.

9. The costs of the appeal shall be distributed in the following manner:

- A. The Liaison Committee on Medical Education shall bear the following expenses:
 - a. The expenses of the LCME staff incidental to the appeals process;
 - b. The expense involved in providing an appropriate meeting facility for the Appeals Board;
 - c. The expenses involved in the travel and maintenance of the Board member named by the LCME Chairman;
 - d. One-half of the expenses involved in the travel and maintenance of the Board member last named.
- B. The institution appealing an LCME decision shall bear the following expenses:
 - a. All expenses involved in the development and presentation of its appeal;
 - b. The travel and maintenance of the Board member named by the institution;
 - c. One-half of the expenses involved in the travel and maintenance of the Board member last named.
- C. No fees or honoraria shall be paid to any member of the Appeals Board except in such case as the Board is required to convene in excess of four full days, in which case each member shall be compensated at a rate of \$200/day, but in no case shall any member be paid in excess of \$1,000. In those cases where compensation for Board members is required in accordance with these procedures, the costs of such compensation shall be split equally between the LCME and the institution.