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

AGENDA

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Thursday, June 20, 1974
9:00 a.m. - 4:00 p.m.
1 Dupont Circle, Rm. 827 (8th Floor)
Washington, D.C.

I. Action Items:

1. All action items in the accompanying Executive Council Agenda
2. Approval of Minutes of CAS Administrative Board Meeting of March 6, 1974 — 1
3. Approval of the Society for Critical Care Medicine
4. Reconsideration of inviting, on a rotating basis, CAS Representatives to meet with Administrative Board

II. Discussion Items:

1. Annual Meeting plans for CAS, COD, COTH Joint Program
2. LCME site visit involvement of Administrative Board members and others from CAS

III. Information Items:

1. NAS-IOM Ethics Seminar Proposal — 7
2. Proposed Seminar for Medical Writers — 10
3. Primary Care Institute Plans — 12
4. State of development of Research Manpower Monitoring System
5. LCGME ad hoc Committee on NIRMP
6. Legislative Report
7. NLM Clearing House Project Report

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

March 6, 1974

Mayflower Hotel
Washington, D.C.

	Board Members	Staff
PRESENT:	Ronald W. Estabrook, Chairman (Presiding)	Michael F. Ball
	Robert M. Blizzard	Connie Choate
	A. Jay Bollet	**John A. D. Cooper
	David R. Challoner	**James B. Erdmann
	D. Kay Clawson	**Charles Fentress
	Jack W. Cole	Mary H. Littlemeyer
	Rolla B. Hill, Jr.	August G. Swanson
	Leslie T. Webster	H. Paul Jolly
		**Emanuel Suter
ABSENT:	Board Members	
	Carmine D. Clemente	
	*Ernst Knobil	
	*Robert G. Petersdorf	

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting held December 13, 1973, were adopted as circulated.

II. Chairman's Report

Dr. Estabrook reported on the AAMC-CAS activities in which he has been involved since the last meeting. These include meetings with the A.M.A. Board of Trustees, NIH Staff, FASEB, and AAMC Biomedical Research and Research Training Committee and a number of other activities through the AAMC Executive Committee.

In an attempt to facilitate communication with CAS constituents, particularly to promote active participation of the constituents in

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*Ex Officio
**For a part of the meeting

charting the course for CAS, Dr. Estabrook wrote 62 personal letters to selected Societies, from which he received seven responses. He also sent 260 personal invitations to the CAS March meetings. From this effort he estimated around a 10% response.

III. Action Items

A. Fall Meetings

ACTION: The CAS Administrative Board voted unanimously to meet with the COD and the COTH in a joint session on Wednesday afternoon, November 13, in a program on (in order of preference): Graduate Medical Education, including the FMG; Allied Health; or Continuing Education.

The CAS business meeting will be held Tuesday morning, November 12, and Tuesday afternoon will be devoted to discussions on national issues with such guests as Henry Simmons to discuss development of PSRO's, Don Frederickson to discuss the IOM Study on the cost of medical education, or an interim report on HR1, with the possibility of Frank Rauscher, NCI, and Ted Cooper, NHLI, on a panel with 20-minute presentations each, followed by a 25-minute reactor panel.

The format for the fall meetings at this time is shown below:

AAMC FALL MEETINGS
Conrad Hilton Hotel, Chicago, Illinois
November 12-16, 1974

	M 11	T 12	W 13	TH 14	F 15	S 16
A.M.	Individual Societies Invited to Hold Meetings	CAS Business Meeting	Plenary Session	Plenary Session	Miscellaneous	
P.M.		CAS National Issues Session	CAS-COD-COTH	Assembly	Miscellaneous	

B. New Applications

ACTION: The application for membership of the Society of Critical Care Medicine was deferred, and the Society will be invited to send representatives to the next meeting of the Administrative Board.

ACTION: The application for membership of the Association for Academic Psychiatry was unanimously approved for recommendation to the full Council.

C. Recommendations of the FMG Task Force

ACTION: The CAS Administrative Board voted unanimously to adopt the recommendations of the FMG Task Force as set forth in the Agenda on pages 18-20 with the following amendment:

7. Special categories - The Task Force recognizes two categories of FMG's, which require special consideration. The first category includes FMGs who are seeking limited educational objectives in this country with the full intent of returning to their home country. They may be accepted into special programs without the qualifications contained in the third recommendation of this report, provided these trainees are not permitted to assume any patient care obligations usually required of the members of the housestaff and provided the training thus obtained is not credited toward specialty board qualification in this country.

D. Biomedical Research Manpower Conference

ACTION: The CAS Administrative Board voted unanimously to approve the three recommendations derived from the Biomedical Research Manpower Conference (Seattle/Battelle) held last fall as principles that should be endorsed by AAMC:

1. That the Congress establish a national commission, possibly under the auspices of the National Academy of Sciences, to help in determining the appropriate role for the federal government in the support of biomedical research and research training, with particular attention to the mission of its principal agency, the National Institutes of Health. Such a commission should have broad representation from business, labor, consumers, foundations, the scientific community, and other interested parties.

2. The Association of American Medical Colleges should take a leadership role in the evaluation of needs for manpower development and should call upon the assistance of voluntary health agencies. This program should also involve the biomedical scientific societies participating in the Council of Academic Societies of the AAMC in order to obtain a broad consensus of needs. The informed support of business, labor, and individual citizens should be utilized to promote a rational, national biomedical research and research training policy. The academic medical community, the professional biomedical scientific associations and the voluntary health agencies should also develop mechanisms to foster public education regarding the implications of biomedical research programs on the public and individual health of the American citizens.

3. A study group should be established to evaluate biomedical research from the standpoint of optimizing contributions to health care and suggesting guidelines for the allocation of resources to basic and applied research. This group will require input of biomedical scientists and should include among its topics for consideration the factors which contribute to the career choice of students who enter biomedical research.

E. Resolution

ACTION: The CAS Administrative Board authorized the Chairman to write a letter on behalf of the Board to the family of the late Dr. Louis Welt in appreciation of his many and significant contributions to the AAMC.

F. OSR Plans

ACTION: After reviewing the OSR plans for the coming year as presented in the agenda on pages 27-34, the CAS Administrative Board took the following actions:

1. To request of the Executive Council that two members of the OSR be on the "GAP" Task Force.

2. To endorse the concept that the OSR Administrative Board meet in conjunction with the Executive Council; and

3. To invite OSR to submit articles by students for publication in such ongoing AAMC publications as the STudent Affairs Report (STAR) as opposed to the initiation of a separate OSR newsletter.

G. NIRMP Progress Report

ACTION: The CAS Administrative Board voted unanimously to recommend to the Executive Council that it establish a Task Force to evaluate in detail the NIRMP and to produce recommendations to make NIRMP a viable service in this era when the interface between undergraduate and graduate education has become quite complex.

H. Setting of AAMC Priorities

ACTION: The CAS Administrative Board voted unanimously to approve the following proposal for setting of AAMC priorities:

1. That the AAMC continue the procedure of holding a retreat for the purpose of establishing goals and priorities;

2. That the AAMC Executive Council and Administrative Boards, as part of their September meetings, discuss the agenda of the retreat and suggest items which they feel to be pressing concerns which the Association needs to address in the coming year. The full Councils will also be asked to contribute suggestions at their November meetings. The staff in conjunction with the AAMC Chairmen should continue to organize and coordinate the agenda items.

3. That the retreat continue to be scheduled between the Annual Meeting and the first Executive Council meeting. The timing between these functions should be relaxed to allow more time for circulation of the retreat agenda and to allow more time for circulation to the Executive Council of the retreat recommendations.

4. That the first meeting of the Executive Council be held in January and be expanded to two days (Thursday and Friday). Administrative Board meetings would then be shifted back to Wednesday. Title VI, Section 4 of the AAMC Bylaws should be amended to read, "The annual meeting of the Executive Council shall be held within 120 days after the annual meeting of the Assembly. . ."

I. Future Meetings

ACTION: The CAS Administrative Board voted unanimously to invite the COTH Administrative Board to a dinner meeting prior to the June meetings of the Board to discuss mutual interests. It was specified that the agenda should be developed with the COTH Administrative Board.

ACTION: The CAS Administrative Board voted unanimously to invite on a rotating basis representatives from the societies to meet with the Board.

IV. Information Items

The following items of information were presented:

1. Letter from the American Association for the Study of Liver Diseases
2. MCAAP Program
3. Anonymous letter regarding Hahnemann Medical College
4. Minutes of Research Manpower Meeting
5. AAMC Education News
6. National Health Insurance Task Force
7. Institute on Primary Care
8. President Nixon's fiscal 1975 budget
9. National Health Policy Development Act of 1974
10. Legislation Deferring Implementation of Section 227-PL92-603
11. AAMC Response to Preadmission Certification Regulation
12. Ethical Aspects of Biomedical Research
13. Report of Biomedical Research and Research Training Committee
14. CCME, LCGME Reports
15. Responses to Dr. Estabrook's letter re plans for CAS
16. AAMC/AADS/NLM Educational Materials Project

V. Federal Legislation

AAMC President, Dr. John A. D. Cooper, and Charles Fentress, AAMC Director of Public Information, joined the Administrative Board for this discussion.

VI. Adjournment

The business meeting was adjourned at 5:00 p.m. and was followed by a dinner meeting with Lionel Bernstein, M.D., Deputy Assistant Secretary for Planning and Evaluation - Health, Department of Health, Education, and Welfare.

MHL:cc

NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE

May 6, 1974

Michael F. Ball, M.D.
Association of American
Medical Colleges
1 Dupont Circle
Washington, D.C. 20036

Dear Mike Ball:

Larry Tancredi has filled me in on the discussions that he has been having with you and Marjorie Wilson concerning the possibilities of a one-day workshop on the teaching of medical ethics. He indicated to me that the initial plans were to hold this conference sometime early June for the medical students, hospital administrators and deans involved with the various councils of the AAMC when they meet at that time. As you know, Larry felt on reflection that it would be difficult to organize a meaningful one-day conference in such a short period of time. He recommended instead that we hold this workshop at the September meeting of the AAMC councils.

The intention of the workshop as I understand it is to examine some of the broad medical socioeconomic issues of an ethical nature from the standpoint of how these issues can be imparted to students in the teaching situation. Larry felt that as a starting point for preliminary discussions with your staff, we might consider having the following papers presented with adequate time for questions from those attending the conference.

The introductory paper should present an overview of the educational objectives that are to be achieved in the teaching of ethical issues involving medical care. No doubt, the presenter of this topic would look at the areas of traditional medical ethics, that is, those value problems that emerge in the individualized physician-patient relationship, be it in therapy or in experimentation, and demonstrate how these issues are related to the broader social justice issues concerning the distribution of medical services.

The presentations following the introductory remarks would deal with specific topic areas:

1. The justice issues of how money and resources should be allocated in health care. This topic would deal with the concept of the preciousness of life from the standpoint of government decision making. For example, it might include an analysis of the implications of the recent passage of the provision in the social security amendments which cover treatment of end-stage renal disease. In selecting one category of disease, what happens to those who are suffering from other conditions which may also be very expensive and require life-saving technology? How are decisions made regarding government allocation programs and what are the value questions that should be elucidated when such decisions are being made?

2. The ethical responsibility of those participating in accountability and accreditation processes. Hospital committees such as tissue review and utilization committees as well as accreditation bodies as the JCAH and the Liaison Committee on Medical Education are empowered to assess and monitor various functions in the medical system. These committees receive their authority from society and therefore are invested with an ordering of responsibilities not only to the providers of medical care but also to the consumers and the society in general. With the emergence of large-scale peer review through PSRO's, the issues surrounding the ethical responsibility of such monitoring groups becomes particularly important. The medical students of today are more and more likely to become participants in one way or another on such review committees.

3. The value assumptions of various settings for providing care to patients. This area is receiving particular attention at the present time with the possible development of a national health insurance system. The care settings which range from the individual proprietorship or fee-for-service medicine to highly organized prepaid settings such as health maintenance organizations affect considerably the way in which care is provided to consumers. Each of these settings creates its own incentives for the provider of care and thereby influences the benefits which are received by the patient. Inevitably some of the ethical considerations surrounding medical settings are related closely to those involved in decisions regarding resource allocation.

In addition to presentations of specific ethical concerns in the broader socioeconomic features of medical care, there should also be a general presentation at the conclusion of the workshop which presents an overview of some of the existing programs in the teaching of medical ethics. This overview should discuss not only the advantages but also the pitfalls and limitations of various teaching programs.

If the AAMC is interested in our proposal for a workshop, we would strongly recommend that it be a joint effort. The Institute of Medicine would be willing to pay the travel and living expenses of the speakers as well as the remuneration for commissioned papers. We would intend that these papers be submitted in a publishable form so that in addition to a conference, we might be able to more widely distribute the results of the workshop.

The above outline for the one-day workshop is tentative, and we would very much like your reaction to it and suggestions for appropriate speakers. We could hold the conference in one of the lecture rooms of the National Academy of Sciences if it would be acceptable to you. Please let us know as soon as possible your response to this proposal and your willingness to enter into a joint effort with the Institute of Medicine. Perhaps we can plan on scheduling the one-day workshop for September 19th which I understand would be free according to your schedule for the various councils.

Looking forward to hearing from you as soon as possible.

Sincerely yours,

Roger

Roger J. Bulger, M.D.
Executive Officer
387-6688

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

Retain – 6 mos.	☐
1 yr.	☐
5 yrs.	☐
	☐
Permanently Follow-up Date	☐

DATE May 10, 1974

TO: Drs. J.A.D. Cooper, J. F. Sherman, A.G. Swanson M. Ball

FROM: Charles Fentress C.F.

SUBJECT: Proposed Seminar for Medical Writers

The American Cancer Society for years has held an annual seminar for writers for the lay press. It is held at some pleasant resort at a desirable time of year and medical writers for newspapers, wire services and magazines attend at their own expense. Leaders in cancer research and treatment are brought in to meet the writers in a series of structured programs and there is a free flow of questions and answers after the initial presentation. The ACS meeting lasts five days. The most recent one drew 75 writers and produced five successive stories in The New York Times. I don't know how many stories were filed by the other 74 writers.

The American Heart Association recently decided to initiate the procedure. Its four-day meeting in Florida, the first, drew 50 writers.

I would like for the AAMC to imitate the procedure on behalf of medical education and biomedical research. I would envision a two or two-and-a-half day affair devoted to curriculum innovations, the pressures exerted on the schools due to increased demands from Federal and state legislation coupled with decreasing financial support, and advances in biomedical research. Since the ACS and the Heart Association hold their own writers meeting, I would suggest we avoid covering research in these areas.

The advantages of holding a seminar are several:

1. The cost is low. The writers pay their own expenses, except for a reception and dinner. Major costs to us would be exprenses of the distinguished experts we bring in, plus the reception and dinner. Preliminary estimates for a two-day meeting, with ten experts present, would run around $8,000.

2. There would be immediate stories. (The writers have to justify to their editors the expense of their trips.)

3. Much would be accomplished in increasing their long-range understanding of medical school problems, which would continue to pay off long after they had gone home.

I have taken the idea to Jay Tuck of The National Fund for Medical Education. He liked it and took the request for support to the Fund's Executive Committee when they met on May 8. The Committee liked the proposal, but decided to defer action until their next meeting, June 11. They request a program outline, a list of possible program participants and a detailed budget for the June meeting.

TENTATIVE PROGRAM

Association of American Medical Colleges

INSTITUTE ON PRIMARY CARE

Hyatt Regency O'Hare, Chicago, Illinois

October 6-8, 1974

SUNDAY, OCTOBER 6

9:00 a.m. - 6:30 p.m.		Registration
12:30 - 5:00 p.m.		Lunch & Orientation Session for Program Participants
5:30 - 6:30 p.m.		Informal Reception
6:30 - 8:00 p.m.		Dinner
8:00 - 9:00 p.m.		**FIRST PLENARY SESSION/ISSUES IN PRIMARY CARE** *Presiding: Thomas E. Piemme, M.D.*
	Welcome	John A. D. Cooper, M.D.
	Address	**"Issues in Primary Care: The Academic Perspective"** by Robert G. Petersdorf, M.D.
	Address	**"Issues in Primary Care: The Policy Perspective"** by Rashi Fein, Ph.D.

MONDAY MORNING, OCTOBER 7

7:30 a.m. - Noon		Registration
9:00 a.m. - 12:30 p.m.		**SECOND PLENARY SESSION/ORGANIZATION OF MODEL SYSTEMS FOR PRIMARY CARE PRACTICE & EDUCATION** *Presiding: Henry M. Seidel, M.D.*
9:00	Introduction	**"Problems and Issues"** by Henry M. Seidel, M.D.
9:15	Address	**"Use of Existing Institutional Resources"** by Thomas L. Delbanco, M.D.
9:45	Responses	Thomas P. Almy, M.D. & John L. Roglieri, M.D.
10:15	Discussion	Institute Participants
10:30	**COFFEE BREAK**	
11:00	Address	**"Use of Community/Private Sector Resources"** by Robert L. Evans, M.D.
11:30	Responses	Edward J. Kowalewski, M.D. & Harold B. Wise, M.D.
12:00	Discussion	Institute Participants
12:30	**Adjourn for Lunch**	

MONDAY AFTERNOON, OCTOBER 7

2:00 - 5:30 p.m.		**THIRD PLENARY SESSION/EDUCATION OF NEW HEALTH PRACTITIONERS** *Presiding: Alfred M. Sadler, Jr., M.D.*
2:00	Introduction	**"Problems and Issues"** by Alfred M. Sadler, Jr., M.D.

2:15	Address	**"Training the New Health Practitioner"** by Charles E. Lewis, M.D.
2:45	Responses	David McK. Lawrence, M.D., M.P.H. & Robert E. Jewett, M.D.
3:15	Discussion	Institute Participants
3:30	**COFFEE BREAK**	
4:00	Address	**"Training for Team Practice"** by David A. Kindig, M.D.
4:30	Responses	Malcolm L. Peterson, M.D. & Walter O. Spitzer, M.D.
5:00	Discussion	Institute Participants
5:30	**ADJOURNMENT**	

MONDAY EVENING, OCTOBER 7 — **FREE**

TUESDAY MORNING, OCTOBER 8

9:00 a.m. - 12:30 p.m.		**FOURTH PLENARY SESSION/GRADUATE PHYSICIAN TRAINING IN PRIMARY CARE** *Presiding: Joel J. Alpert, M.D.*
9:00	Introduction	**"Problems and Issues"** by Joel J. Alpert, M.D.
9:15	Address	**"Training of Generalists in Medicine and Pediatrics"** by Evan Charney, M.D.
9:45	Responses	Joseph L. Dorsey, M.D. & Arnold S. Relman, M.D.
10:15	Discussion	Institute Participants
10:30	**COFFEE BREAK**	
11:00	Address	**"Training of Family Practitioners"** by Robert E. Rakel, M.D.
11:30	Responses	Eugene S. Farley, Jr., M.D. & Thomas E. Piemme, M.D.
12:00	Discussion	Institute Participants
12:30	**Adjourn for Lunch**	

TUESDAY AFTERNOON, OCTOBER 8

2:00 - 3:45 p.m.		**FIFTH PLENARY SESSION/NEW DIRECTIONS IN HEALTH SCIENCE EDUCATION** *Presiding: Steven A. Schroeder, M.D.*
2:00	Address	**"Priorities for Health Science Education in the Next Decade"** by David E. Rogers, M.D.
2:30	Responses	Hilliard Jason, M.D. & Jack D. Myers, M.D.
3:00	Discussion	Institute Participants
3:45	**ADJOURNMENT**	

PROGRAM PARTICIPANTS

THOMAS E. PIEMME, M.D., *Institute Chairman;* Director, Division of General Medicine, George Washington University School of Medicine

STEVEN A. SCHROEDER, M.D., *Institute Co-Chairman;* Associate Professor, Division of General Medicine, George Washington University School of Medicine

THOMAS P. ALMY, M.D., Third Century Professor of Medicine, Department of Medicine, Dartmouth Medical School

JOEL J. ALPERT, M.D., Chairman, Department of Pediatrics, Boston University School of Medicine

EVAN CHARNEY, M.D., Associate Professor, Department of Pediatrics, University of Rochester Medical Center

JOHN A. D. COOPER, M.D., President, Association of American Medical Colleges

THOMAS L. DELBANCO, M.D., Medical Director, Division of Ambulatory Care, Beth Israel Hospital

JOSEPH L. DORSEY, M.D., Medical Director, Harvard Community Health Plan

ROBERT L. EVANS, M.D., Dean, University of Illinois, Rockford School of Medicine

EUGENE S. FARLEY, JR., M.D., Professor and Director of Family Medicine, University of Rochester School of Medicine and Highland Hospital

RASHI FEIN, Ph.D., Professor of the Economics of Medicine, Center for Community Health & Medical Care, Harvard Medical School

HILLIARD JASON, M.D., Director, Division of Faculty Development, Association of American Medical Colleges

ROBERT E. JEWETT, M.D., Director, Division of Allied Health Professions, Emory University School of Medicine

DAVID A. KINDIG, M.D., Co-director, Institute for Health Team Development

EDWARD J. KOWALEWSKI, M.D., Professor and Head, Family Practice Program, University of Maryland School of Medicine

DAVID McK. LAWRENCE, M.D., M.P.H., Director of the MEDEX Northwest Program, Assistant Professor, Department of Health Services, University of Washington School of Public Health and Community Medicine

CHARLES E. LEWIS, M.D., Professor of Public Health and Professor of Preventive & Social Medicine, UCLA School of Medicine

JACK D. MYERS, M.D., University Professor of Medicine, University of Pittsburgh School of Medicine

ROBERT G. PETERSDORF, M.D., Chairman, Department of Medicine, University of Washington School of Medicine

MALCOLM L. PETERSON, M.D., Dean, Johns Hopkins University School of Health Services

ROBERT E. RAKEL, M.D., Chairman, Department of Family Practice, University of Iowa College of Medicine

ARNOLD S. RELMAN, M.D., Chairman, Department of Medicine, University of Pennsylvania School of Medicine

DAVID E. ROGERS, M.D., President, The Robert Wood Johnson Foundation

JOHN L. ROGLIERI, M.D., Chief, Medical Clinics, The Presbyterian Hospital, Columbia-Presbyterian Medical Center

ALFRED M. SADLER, JR., M.D., Assistant Vice President, The Robert Wood Johnson Foundation

HENRY M. SEIDEL, M.D., Associate Dean, Johns Hopkins University School of Health Services

WALTER O. SPITZER, M.D., Associate Professor, Department of Clinical Epidemiology and Biostatistics, McMaster University Health Sciences Centre

HAROLD B. WISE, M.D., Project Director, Internship & Residency Program in Social Medicine, Montefiore Hospital and Medical Center

American Association

of

Chairmen of Departments of Psychiatry

DATED: May 5, 1974
Detroit, Michigan

R E S O L U T I O N

The American Association of Chairmen of Departments of Psychiatry recommend that:

1. The requirement should be restored for at least one year of post-doctoral education primarily devoted to clinical care of physically ill patients (i.e. comparable to a year of internship) either prior to three years of psychiatric residency or combined with it into a four year program, as prerequisite to examination in Psychiatry by the American Board of Psychiatry and Neurology;
2. Such restoration should be accomplished as swiftly as possible, preferably by July 1, 1976, but in any event no later than July 1, 1977,
3. Prior to such restoration all applicants for psychiatric residencies should be advised of the desirability of obtaining an internship or its equivalent, and of the Board's intention to reinstate this requirement, and
4. Meanwhile every effort must be made to meet the following prerequisite needs:
   A. To identify sufficient numbers of first year post-doctoral programs in internal medicine, pediatrics, family medicine and the like, to accommodate subsequent residents in psychiatry;
   B. To ensure that such programs will not discriminate against applicants who plan careers in psychiatry; and
   C. To provide a sufficient number of stipends for these positions, in appropriate teaching hospitals, so that all prospective residents in psychiatry can obtain this required year of education.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 301. 1776 MASSACHUSETTS AVENUE. N.W.. WASHINGTON. D.C. 20036

May 7, 1974

M E M O R A N D U M
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TO: Admissions Officers of U.S. Medical Schools
Chief Premedical Advisors of U.S. Undergraduate Colleges

FROM: Davis G. Johnson, Ph.D., Director, Division of Student Studies

SUBJECT: Encouraging Findings of New Study of Early Decision Plan

* *

A new study of experience with the Early Decision Plan (EDP) for the 1974-75 entering class offers considerable encouragement to both admissions officers and preprofessional advisors. Significant findings of this study include the following:

1) almost twice as many EDP applicants (52%) as non-EDP applicants (28%) had been admitted to Medical School as of April, 1974;

2) of those EDP applicants accepted to date, 69% were admitted to their EDP choice schools under Early Decision (i.e., by October, 1973), 18% were admitted to their EDP choice schools as regular candidates (i.e., after October, 1973) and 13% were admitted to schools not participating in EDP. Thus it would appear that candidates not admitted under EDP still have a reasonable chance for admission at a later date;

3) although applicants accepted early by EDP schools have slightly stronger credentials (e.g., grade point averages of 3.6 and Science MCAT of 637) than those accepted by all Medical Schools (GPA of 3.5 and Science MCAT of 610), those admitted later to EDP schools have slightly weaker credentials (3.4 and 604) than those of acceptees in general;

4) since EDP applicants accepted by their EDP choice schools as regular candidates have slightly lower credentials (3.4 and 604) than those accepted to non-EDP schools (3.5 and 624), it appears that admissions committees may be giving some preference to applicants who indicate by participating in EDP that their school is definitely their first choice;

5) over 5,000 needless applications were prevented by the use of EDP. Since the applicants accepted early under

(over)

EDP were a particularly well-qualified group, they would have required even more travelling, advising, interviewing, committee discussion, etc., than the ordinary applicants. Thus the saving in time and money on the part of applicants, advisors and admissions officers was even greater than that represented by 5,000 typical applications.

It is hoped that the above information and the additional details provided in the attached table will be of immediate help in advising applicants about applying to the 59 schools using EDP in the selection of their 1975-76 entering classes.

The growing popularity of EDP is evidenced by 59 schools using EDP in selecting their 1975-76 entering class as compared with 51 schools using it last year. Of the 59 schools using EDP for 1975-76, all but 8 are also participating in AMCAS and are identified in the AMCAS Information Booklet and on the blue AMCAS Designation Form (which also provides for a signed declaration regarding the provisions of EDP). The 8 EDP schools not participating in AMCAS are Baylor, Boston University, Brown, Dartmouth, Johns Hopkins, Kansas, Meharry and New York Medical College. All schools using EDP are identified in their two-page entries in the 1975-76 edition of Medical School Admission Requirements.

Questions and/or comments concerning this study should be directed to the Division of Student Studies. General information about the actual administration of EDP for 1975-76 may be found on page 26 of Medical School Admission Requirements, 1975-76, and on page 2 of the AMCAS Instruction Booklet for 1975-76 Entering Class.

DGJ/bkg 5/7/74
Attachment

CC: Selected AAMC Staff

W# 8363

AAMC DIVISION OF STUDENT STUDIES

Comparison of EDP & Total Applicants for 1974-75 Entering Class

VARIABLE (1)	EDP APPLICANTS TO 43 AMCAS SCHOOLS USING EDP AS OF 4/12/74: Accepted by EDP Schools Early (2)	Accepted by EDP Schools Later (3)	Acc. by non-EDP Schools (4)	Total Accepted (5)	Not Accepted (6)	Total Applicants (7)	TOTAL APPLICANT POOL (as of 4/26/74): Applied (8)	Accepted (9)
a) Applicants	550	142	105	797	747	1,544	39,986	11,245
b) % accepted to date	#	#	#	52%	#	#	#	28%
c) % EDP accepted	69%	18%	13%	100%	#	#	#	#
d) Mean GPA	3.6	3.4	3.5	3.5	3.2	3.4	3.2	3.5
e) MCAT								
Verbal	566	551	558	555	525	554	533	567
Quantitative	630	615	620	626	585	606	576	616
General Info.	567	553	556	563	527	546	535	564
Science	637	604	624	629	561	596	558	610
f) Applications per Applicant	1	6	11	3	6	5*	8*	@

*Since the 1,544 EDP applicants in this study filed an average of 3 fewer applications than did applicants in general, there was a saving of 3 x 1,544 or 4,632 applications for this group alone. Assuming the same experience for the 249 EDP applicants to non-AMCAS schools, there would be an additional saving of 3 x 249 or 747 applications for a total estimated saving of 5,379.

#No figures are entered because they would not be applicable to the given variable.

@The average number of applications per accepted applicant is not known as of this date.

W#8363-T

DGJ/bkg 5/7/74

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

May 17, 1974

Ronald Estabrook, Ph.D., Chairman
Council of Academic Societies
1 DuPont Circle, N.W.
Washington, D. C. 20036

Dear Doctor Estabrook:

I am returning herewith the bill sent to the Treasurer of The American College of Obstetricians and Gynecologists for the College's dues to the Council of Academic Societies for the period July 1, 1974 through June 30, 1975.

At its recent meeting, the Executive Board of the College considered the proposed increase in the College's dues to the Council from $100 to $3000 per annum and voted to withdraw from participation in the Council. This withdrawal will be effective June 30, 1974. In taking this action, members of the Board felt that there had been limited explanation and justification of the new programs that required such an increase in dues. Moreover, the involvement and participation of the College in the Council did not warrant such expenditure.

Sincerely yours,

Michael Newton

Michael Newton, M.D., FACOG
Director

MN/ja.
cc/Henry A. Thiede, M.D., FACOG
Allan B. Weingold, M.D., FACOG
enc.

One East Wacker Drive • Chicago, Illinois 60601 • Telephone (312) 222-1600

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

For the Executive Council's

Consideration

June 21, 1974

A Statement of Policy Relating to

FINANCING

UNDERGRADUATE MEDICAL EDUCATION

REPORT OF THE COMMITTEE ON THE
FINANCING OF MEDICAL EDUCATION

Charles C. Sprague, M.D., Chairman

May, 1974

FOREWORD

The Committee on the Financing of Medical Education was formed by the Association of American Medical Colleges "to conduct and sponsor studies designed to provide the data base for recommendations on matters of policy relating to medical education and its financing."

This report presents the Committee's views and recommendations for financing the educational program leading to the M.D. degree. The proposals are presented for the evaluation by all who are concerned with furthering the Nation's achievements in health, with the hope that this statement will lead to further discussions among the medical education community, Congressional and government officials, and the public.

The statement complements and carries forward the Committee's report on the cost of the undergraduate medical education process. The cost study, published in the January 1974 issue of the Journal of Medical Education is, therefore, an integral part of this presentation.

Further areas relating to medical education, such as the requirements for physical facility renewal and expansion, will be the subjects of subsequent reports.

The Association wishes to express its appreciation for the financial assistance it has received from the National Fund for Medical Education in supporting the work of this Committee.

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Committee Chairman,
University of Texas,
Health Sciences Center at Dallas

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Background

In the foreword to its first report, Undergraduate Medical Education -- Elements - Objectives - Costs, [1] the Association's Committee on the Financing of Medical Education indicated its intention to present its views of the mechanism through which the costs of undergraduate medical education should be financed. The Committee stated that "An equitable distribution of these costs among the immediate beneficiaries of the process and society, and the maintenance of the institutions in which the educational process necessarily takes place must be assured if the benefits which have flowed from the medical school are to continue to play their important role in advancing the health of the Nation."

[1] See Journal of Medical Education, vol. 49, No. 1, January 1974, pp. 97-128.

Before the Committee's views on undergraduate medical education financing are presented, it is necessary, for perspective, to summarize the findings from the Committee's first report, which showed that - - -

(1). The estimated annual cost per medical student of the education program leading to the M.D. degree ranges from $16,000 to $26,000 (in 1972 dollars). These estimates are based on an intensive review of data relating to the undergraduate medical education program provided by the cost allocation studies completed by a selected group of twelve medical schools, and of supplementary information developed by these institutions, and by the Committee. In order to reflect comparable and conceptually consistent cost data, the estimates include imputations for services essential to the undergraduate medical education program, but which are provided at no direct cost to the medical school. An example is the service of voluntary faculty in the education of undergraduate medical students.

(2). The educational program leading to the M.D. degree - - - a complex inter-weaving of elements of instruction, research, and exposure to clinical practices and procedures - - - can only be provided in the institutional setting of the contemporary medical school. This institution is responsible not only for undergraduate medical education, but also for directing and conducting the necessary additional formal training at the graduate level in particular areas of medicine requisite for the individual or group practice of medicine; for

programs in continuing education for practicing clinicians, so that they can keep abreast of the advances in technology and medical practice; and for the training of students in other health professions and ancillary health occupations. These responsibilities in education, together with the medical schools' essential activities in biomedical research and clinical services to the community, constitute the complex set of inter-related programs of the contemporary medical school.

(3). Some portion of these inter-related activities are accomplished jointly, that is, the instruction of undergraduate medical students may take place together with instruction of graduate medical students. And faculty involvement in research and clinical services is also essential for the full-development of the student. The determination of the proper allocation of the costs of these jointly produced activities (and therefore, the equitable allocation of their individual financing) must rest on a series of assumptions, since there is no fundamental basis for the allocation of joint costs to the individual purposes served.

(4). The continuation of the medical school's capability to meet all of these National objectives in health - - - to educate, to advance biomedical knowledge through research, and to care for the health needs of the community - - - is dependent upon the continuing productivity, viability, and fiscal stability of the institution as a whole.

Relation of Costs
To Financing

The cost estimates by the Committee, reflect the full cost of all the resources that must be available to the medical school for the undergraduate medical education program. But it is necessary to draw a distinction between these measures of the full cost of the program, and the amount that must be financed by medical schools from general funds or from sources directed specifically to the undergraduate medical education program.

The full resource cost estimates include imputations for the cost of resources, necessary for the educational process, but which are either contributed freely, or not accounted for fiscally. These imputed costs, which do not have to be financed so long as the contributed services continue to be available, represent about 15 percent of the estimated full resource cost of the program.

In addition, the Committee's full resource cost estimates properly reflect the levels of research and clinical activity

necessary for the training of the undergraduate medical student by a faculty abreast of the advances in biomedical knowledge and the modern practice of medicine. It is not necessary, however, for the medical school to finance the full costs of these joint activities as a cost of the undergraduate medical education program. In the case of research, a large portion of this activity is already financed by Federal agencies sponsoring biomedical research. The Committee, therefore, recognizes that the net cost of the research component necessary for undergraduate medical education is the difference between the full cost of that component and the amount made available to the medical school from the sponsoring source and that a portion of this net educational cost is allocable to the undergraduate medical education program. In the case of the clinical activity, the Committee recognizes that in some instances the income to the medical school from a medical service plan provides support for a portion of the clinical activity essential for the education program. Therefore, the net cost of the clinical activity necessary for the M.D. program is the difference between the full cost of this component and the medical service income allocable to the undergraduate medical education program.

For the twelve medical schools studied by the Committee, the net costs of the medical education program that remain to be financed as educational costs are shown in table 1 where they are compared with the full resource cost of the program. The annual cost for all the resources required for the education program range from $16 to $26 thousand per student. When account is taken of contributed services and the funds for education derived from the joint activities of research and clinical activity, the estimates of the annual educational cost of the M.D. program not financed by contributed services, or income from research and clinical activity range from $9 to $19 thousand per medical student, or an average of $12,500 per student. (See Technical Note, p. 22 for the methodology used in determining these costs).[2]

[2]The Institute of Medicine, applying a somewhat different methodology to a different set of medical schools, found the average net educational expenditure for undergraduate medical education to be $9,700 per student per year. See "Costs of Education in the Health Professions," Parts 1 and 2, January 1974.

It must be emphasized, however, that all of the education costs must continue to be financed. Any reduction in the contribution of voluntary faculty, or in sponsorship of research activities, will have to be made up by income from other sources if the institution is to carry forward the educational program leading to the M.D. degree.[3]

Table 1

Annual Cost per Student - Undergraduate Medical Education
Twelve Medical Schools
(In Thousands of 1972 Dollars)

	Full Resource Cost				Education not financed by contributed services or income from research and clinical activity			
School	Total	Instruct., Admin., & Other Prof. Activities	Resch.	Clinical Activity	Total	Instruct., Admin., & Other Prof. Activities	Resch.	Clinical Activity
A	$24.1	$11.7	$9.5	$2.9	$14.8	$10.4	$1.5	$2.9
B	26.4	12.6	10.0	3.8	18.1	10.8	4.0	3.3
C	16.3	7.4	7.3	1.6	12.1	6.8	3.9	1.4
D	16.7	11.2	2.7	2.8	9.5	7.9	.4	1.2
E	16.5	9.1	4.3	3.1	10.3	7.7	.4	2.2
F	16.9	8.8	6.4	1.7	9.4	7.5	1.9	---
G	19.9	12.2	5.4	2.3	13.9	9.6	2.2	2.1
H	22.3	12.1	7.1	3.1	12.8	10.4	.4	2.0
I	21.0	11.2	5.1	4.7	13.3	9.5	2.0	1.8
J	23.8	12.8	6.4	4.6	19.3	11.1	4.1	4.1
K	24.1	11.9	9.5	2.7	11.3	8.9	2.4	---
L	16.4	9.2	3.7	3.5	10.8	7.6	.7	2.5

[3]The Committee is concerned that the research program of some of the Nation's medical schools may not be adequate to provide the faculty with sufficient opportunity for the scholarly activities necessary to maintain their competence as educators. For these schools either a greater proportion of the necessary research activities will have to be funded as educational costs, or increased sponsored research support will have to be obtained.

Obviously, fiscal stability may be assured where the total costs of the instituion are covered by its total income. But this may be accomplished where the revenue from an individual program is greater than the cost of that activity, thus making up the deficit, if any exists, in income over cost for some other activity. It is not the contention of the Committee that such a situation is necessarily undesirable, but an institution's fiscal stability, and an equitable distribution of program costs is more assured where, to the maximum feasible extent the revenues associated with individual programs and services are substantially in balance with the institution's cost of providing them.

Thus, consideration of the cost-income balance for each and all programs is essential for a full understanding of medical school finances. Comprehensive and conceptually consistent cost information is presently available, however, only for the undergraduate medical education program. The Committee's primary focus at this time on this one aspect of the medical school should not be construed, therefore, as a lack of awareness of the importance and significance of other activities in their impact on the over-all fiscal strength of the institution.

Current Funding Patterns -
Medical School Programs

The Committee's effort to determine the current patterns of income for financing undergraduate medical education has necessarily been conditioned by - - -

(1) the accounting conventions and fiscal reporting practices followed by the medical schools. These institutions provide data to show income by source, but the end-purpose supported by the funds is clearly delineated only where funds are made available for a specific purpose, such as the sponsorship by an agency of the Federal Government of research performed by a member of the medical school faculty, or where the medical school enters into a contractual arrangement with a State or local government agency to provide health services to a neighborhood community, or where, as in recent

years, the Federal Government has provided funds for strengthening and maintaining undergraduate medical education programs, in recognition of the medical schools' need for such specific support. Medical schools' revenues are reported in two broad categories - - - only by income source for support of the regular operating programs of the schools, and by source and purpose where the funds are to be used only for specific activities as directed by the income source. For the 1971-72 academic year, medical schools awarding the M.D. degree reported receiving $870 million for the support of their (undifferentiated) operating programs, and $1,053 million for the conduct of specific sponsored activities.

(2) the complex nature of the undergraduate medical education process itself, composed of elements of instruction, research, and clinical practices. These elements are conducted, to some degree, jointly with other programs, and may therefore, be (partially or wholly) financed by funds obtained for these other end-purpose activities; and

(3) the differing financial characteristics and sources of income of publicly-owned medical schools as compared with private institutions. The privately operated medical schools have no single source of income for their regular operating programs comparable to the funds provided by State governments to publicly owned schools; for both categories of schools however, the funds received from all sources for the support of operating programs are not differentiated by program.

Since the conventional reporting of fiscal information is inadequate for determing the income flows to support particular operating programs of the medical school, the Committee has also made use of whatever additional insights are provided by the cost allocation studies completed by the twelve medical schools selected for the Committee's study of the cost of undergraduate medical education. Cost allocation studies, however, are conducted primarily to provide the institution with a better understanding of the distribution of costs within the institution, and only incidentally and therefore not consistently or completely to allocate income flows to specific programs.

An over-view of medical school expenditures for all operating and sponsored programs, and the sources of funds supporting these programs is presented in Tables 2 and 3.[4]

The pattern that emerges is one of both considerable similarity in the sources of income utilized by private medical schools (as a group) and public medical schools (as a group) but considerable variation in the degree of reliance by these groups upon a particular income source.

[4]The analysis of income sources and expenditures for the private and public medical schools first appeared as a Datagram, in Journal of Medical Education, vol 47, No. 7, July, 1972, pp.579-584; information for the academic year 1971-72, the latest available, has been added to the previously published data.

The data are derived from the annual financial questionnaire administered jointly by the American Medical Association and the Association of American Medical Colleges, and cover the fully operational medical schools awarding the M.D. degree. Since 1961, the number of private schools included in this group has remained constant at 44; the number of publicly owned medical schools, however, has increased from 37 in 1961 to 50 in 1972. In 1961, the total number of all students including medical students[5] trained by medical school faculty was about equally divided between the private schools (32,000) and the public schools (31,000). By 1972, the teaching load at the private schools increased by 16,000 students to a total of 48,000; in the public group, however, the increase was about 26,000 students to a total of 58,000.

Medical school expenditures in the academic year 1971-72 totaled $1.9 billion with 55 percent of the total accounted for by private medical schools.[6]

Ten years before, total expenditures amounted to $440 million, with the expenditures of private schools also amounting to 56 percent of this total.

Data are presented in Table 2 for each of these two groups of schools showing the sources of funds to defray regular operating costs and to support specific activities (research, training, and multi-purpose service) sponsored by the funding agency.

[5]These include undergraduate medical students, interns, residents, pre- and post-doctoral students in the basic sciences, clinical post-doctoral fellows, and the full-time equivalents of students in other health professions (dental, pharmacy, nursing, and other allied health).

6 The data on income sources and expenditures include only those of the medical school as an organizational unit; revenues and expenditures for the general operation of hospitals and clinics are excluded.

TABLE 2

The Funding of Operating and Sponsored Programs of Private and Public Medical School - 1961-1972*
(millions of dollars)

Income source for expenditures	1960-61 Total	1960-61 Private	1960-61 Public	1965-1966 Total	1965-1966 Private	1965-1966 Public	1970-71 Total	1970-71 Private	1970-71 Public	1971-72 Total	1971-72 Private	1971-72 Public
Total expenditures	$ 438.9	$ 247.1	$ 191.8	$ 883.5	$ 477.9	$ 405.6	$ 1698.8	$ 880.5	$ 818.3	$ 1923.1	$ 1053.9	$ 869.2
Operating programs expen.	216.9	107.8	109.1	368.0	171.8	196.2	779.5	326.6	452.9	870.5	410.7	457.8
Tuition & Fees	28.2	19.9	8.3	41.0	28.7	12.3	62.2	44.9	17.3	77.8	56.0	21.8
State Appropriations	60.6	1.0	59.6	111.9	4.7	107.2	256.9	10.7	246.2	271.4	16.7	254.6
State & Local Gov'mnt Assistance 1/	8.1	7.6	.5	7.6	6.9	.7	22.6	21.4	1.2	36.1	34.9	1.2
Indirect cost recovery, sponsored programs	18.6	11.7	6.9	58.9	35.2	23.7	101.2	66.0	35.2	124.3	81.3	43.0
Professional fee income	12.8	6.7	6.1	25.2	12.0	13.2	114.6	47.5	67.1	141.6	66.7	74.9
Endowment income	15.1	14.5	.6	26.3	24.5	1.8	36.2	34.6	1.6	45.1	42.4	2.7
Gifts	10.8	8.8	2.0	13.8	9.8	4.0	19.7	12.9	6.8	25.6	18.9	6.7
Income from college ser.	6.6	5.5	1.1	14.1	11.4	2.7	22.6	17.8	4.8	40.8	34.6	6.2
Other income sources	32.7	19.9	12.8	47.0	25.7	21.3	111.0	50.4	60.6	73.7	48.5	25.3
Funding of Net excess of expenditures over revenues 2/	23.4	13.2	11.2	22.2	12.9	9.3	32.5	20.4	12.1	34.1	10.7	23.4
Sponsored programs expend.	222.0	139.3	82.7	515.5	306.1	209.4	919.3	553.9	365.4	1052.6	643.3	409.4
Research	167.5	106.5	61.0	375.1	225.6	149.5	471.6	288.5	183.0	548.1	338.4	209.8
Federal government	118.9	73.8	45.1	307.4	184.0	123.4	357.7	210.7	147.0	437.5	269.5	168.0
State, city, local govt	4.6	3.0	1.6	12.1	7.6	4.5	15.9	12.4	3.5	15.2	8.5	6.7
nongovernment sources	44.0	29.7	14.3	55.6	34.0	21.6	97.9	65.4	32.5	95.4	60.4	35.1
Training	49.5	28.1	21.4	122.5	65.9	56.6	220.8	114.5	105.7	252.0	138.2	113.8
Federal government	43.6	24.4	19.2	112.1	59.4	52.7	191.7	101.3	90.4	216.3	122.3	94.0
non-federal sources	5.9	3.7	2.2	10.4	6.5	3.9	28.6	13.2	15.3	35.7	15.9	19.8
Multipurpose programs, (Teaching, services, res.)	5.0	4.7	.3	17.9	14.6	3.3	227.6	150.9	76.7	252.5	166.7	85.8
Federal government	5.0	4.7	.3	17.9	14.6	3.3	127.7	66.2	61.5	100.4	45.5	54.9
Non-federal sources							99.9	84.7	15.2	152.1	121.2	30.9

* Covers fully operational medical schools awarding the M.D. degree; schools of basic sciences and developing schools are not included.

1/ Funds provided to private medical schools to increase enrollment or to provide for the enrollment of residents of the state in which the school is located; and funds provided to private and public medical schools to provide for the enrollment of residents of states without a medical school.

2/ Indicated general university funds, endowment principal, prior year balance, and reserves.

TABLE 3

The Funding of Operating and Sponsored Programs of Private and Public Medical Schools - 1961-1972*
(Percentage Distribution)

Income source for expenditures	1960-61 Total	1960-61 Private	1960-61 Public	1965-66 Total	1965-66 Private	1965-66 Public	1970-71 Total	1970-71 Private	1970-71 Public	1971-72 Total	1971-72 Private	1971-72 Public
Operating programs expen.	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Tuition & Fees	13.0	18.5	7.6	11.1	16.7	6.3	8.0	13.8	3.8	8.9	13.7	4.7
State Appropriations	27.9	.9	54.7	30.4	2.7	54.6	33.0	3.3	54.4	31.2	4.1	55.4
State & Local Gov'ment Assistance 1/	3.7	7.0	.4	2.1	4.0	.4	2.9	6.5	.3	4.1	8.5	.3
Indirect cost recovery, sponsored programs	8.6	10.9	6.3	16.0	20.5	12.1	13.0	20.2	7.8	14.3	19.8	9.3
Professional fee income	6.0	6.2	5.6	6.8	7.0	6.7	14.7	14.5	14.8	16.3	16.2	16.3
Endowment income	7.0	13.5	.6	7.1	14.3	.9	4.7	10.6	.4	5.2	10.3	.6
Gifts	5.0	8.2	1.8	3.8	5.7	2.0	2.5	4.0	1.5	2.9	4.6	1.5
Income from college ser.	3.0	5.1	1.0	3.8	6.6	1.4	2.9	5.4	1.1	4.7	8.4	1.4
Other income sources	15.0	18.4	11.8	12.8	15.0	10.9	10.2	15.4	13.2	8.5	11.8	5.5
Funding of net excess of expenditures over revenues 2/	10.8	11.3	10.2	6.1	7.5	4.7	4.1	6.3	2.7	3.9	2.6	5.1
Sponsored programs expen.	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Research	75.5	76.4	73.7	72.8	73.7	71.3	51.2	52.0	50.1	52.1	52.6	51.2
Federal government	53.6	53.0	54.5	59.6	60.1	58.9	38.9	38.0	40.2	41.6	41.9	41.0
State, city, local govt	2.1	2.1	1.9	2.4	2.5	2.1	1.7	2.2	1.0	1.4	1.3	1.6
Non-government sources	19.8	21.3	17.3	10.8	11.1	10.3	10.6	11.8	8.9	9.1	9.4	8.6
Training	22.3	20.2	25.9	23.7	21.5	27.1	24.0	20.7	28.9	23.9	21.5	27.8
Federal government	19.6	17.5	23.2	21.7	19.4	25.2	20.9	18.3	24.7	20.5	19.0	23.0
Non-federal sources	2.7	2.7	2.7	2.0	2.1	1.9	3.1	2.4	4.2	3.4	2.5	4.8
Multipurpose programs, (Teaching, service, res.)	2.2	3.4	.4	3.5	4.8	1.6	24.8	27.3	21.0	24.0	25.9	21.0
Federal government	2.2	3.4	.4	3.5	4.8	1.6	13.9	12.0	16.8	9.5	7.1	13.6
Nonfederal sources							10.9	15.3	4.2	14.4	18.8	7.6

*Covers fully operational medical schools awarding the M.D. degree; schools of basic sciences and developing schools are not included

1/ Funds provided to private medical school to increase enrollment or to provide for the enrollment of residents of the state in which the school is located; and funds provided to private and public medical schools to procide for the enrollment of residents of states without a medical school.

2/ Indicates general university funds, endowment principal, prior year balance, and reserves

Income for All Operating Expenditures

Currently, the regular operating functions of the public schools account for more than half of the total expenditures; for the privately owned group, this proportion is less than two-fifths. There is also considerable variation between these two groups in the sources of income to defray those costs traditionally associated with the regular operating functions of the medical school.

For the publicly owned schools, funds appropriated by the state legislatures provide more than half of the dollars for maintaining the regular teaching and service functions of the medical school, a proportion that has remained constant for the 1961-1972 period (Table 3). For the most recent year, professional fee income from medical service plans and the recovery of indirect costs to defray overhead costs incidental to the grants and contracts for sponsored programs were the next largest sources of income. Ten years before, income from professional service fees was a relatively insignificant item; however, by 1965 income from this source had exceeded tuition payments.

For the private medical schools, indirect cost recovery and income from professional service fees constitute the most significant income items for the recent period; together they provide one-third of the funds utilized for operating activities. Tuition payments are also an important source of income in private schools, exceeding the amounts provided through gifts and unrestricted endowment income. Both these sources, however, have declined relatively in the period since 1961.

Income for All Sponsored Programs

The sponsored activities of the publicly owned medical schools in 1971-72 comprised less than half their total outlay; but for the private group, these activities account for more than three-fifths of total expenditures.

In absolute terms, funds for sponsored research at the private medical schools have exceeded the dollar totals provided to the publicly owned schools. Since 1961, for both groups of schools, research has declined in relative terms from three-fourths of all sponsored activities to about one-half.

While the levels of support for sponsored teaching and training have increased since 1961, these funds continue to support about one-fourth of all sponsored activities. In absolute terms, the private medical schools have received somewhat larger dollar amounts, but these funds have accounted for a smaller proportion of the total sponsored activities of the private group.

Federal expenditures shown in Table 2 for sponsored teaching and training programs relate principally to the graduate research training programs administered by the National Institutes of Health, and the more modest levels of support (basic support grants and special project grants) provided specifically for undergraduate medical education under legislation enacted in 1966. These expenditures do not reflect the increased levels of Federal support for undergraduate medical education authorized by the Comprehensive Health Manpower Training Act of 1971. Awards to medical schools were first made under that legislative authority in fiscal 1972, but these awards are forward financing, that is, the funds are to support the programs in the ensuing academic year, and, therefore, these awards are reflected in the expenditure data for the 1972-73 academic year.

In recent years, support for funding the projects that bridge teaching, research, and service activities has grown exponentially. These multi-purpose projects include the federal regional medical program, health services provided under contract, and the operation of community health centers and clinics. The private medical schools were more heavily involved financially in these programs than were the public schools. Almost three-fourths of the $165 million received by the private schools for these programs was provided by non-federal sponsors, primarily for the provision of health services under contract programs. For the publicly owned group, multi-purpose activities in fiscal year 1972 totaled $85 million, with the major portion of these funds the result of the involvement of these schools with federally sponsored regional medical programs. The source of funds for similar programs for years prior to fiscal year 1970-71 were not identified in the data collection process; trend analyses are, therefore, not possible.

The discussion has necessarily focussed upon the over-all pattern of medical school financing. The specific pattern for the funding of the undergraduate medical education program is not so readily discernible. The art of program-planning-budgeting has not been applied widely to medical schools, accounting for the financing of activities produced jointly requires judgemental decisions, and medical school financial reports available now do not reflect the full impact of the expanded Federal support enacted in 1971 for the educational program leading to the M.D. degree.

It is clear from the preceding review, that the National involvement - - - through the activities of Federal Government agencies and the importance of state support - - - is crucial to the financing of undergraduate medical education. It is necessary to describe how this development evolved since a continuation of this National involvement is a fundamental part of the Committee's recommendations .

The Evolving Federal Role In Undergraduate Medical Education

While Federal Government utilization of the unique capability of medical schools for the conduct of biomedical research and for the training, at the graduate and post doctoral levels of research investigators, has been of long-standing, only in the past few years has there been direct Federal assistance specifically for undergraduate medical education. (Table 4)

Funds to assist in the construction of teaching facilities and for the establishment of a federally funded student loan program were authorized by legislation enacted in 1963; direct federal funds for the expansion and improvement of undergraduate medical education were allocated for the first time in 1966. These basic support grants were awarded on a formula basis which provided incentives to increase the numbers of enrolled students and graduates. Beginning in 1968, in recognition of the need for further federal assistance, medical schools have been awarded additional funds to help carry forward special projects for curricula improvements or modification; for training specifically for areas of national concern, such as family practice; and to relieve medical schools in financial distress. These forms of assistance were extended and elaborated by the Comprehensive Health Manpower Training Act of 1971. The legislation authorized the continuation of the support for the construction of teaching facilities, for providing financial assistance to students, for special projects for the expansion, shortening and improvement of educational programs, and for the relief of medical schools in financial distress. The principal feature of this legislation, however, is the "capitation grant" based on an amount for each undergraduate student enrolled in each medical school agreeing to expand its entering class in fiscal year 1973 by a specified increment, with an additional bonus for greater first year enrollment increments, and added differential payments for graduates of three-year programs. Financial assistance in the form of conversion grants is also provided to schools moving to M.D. degree granting programs from a two-year basic science curriculum; and new schools are eligible for start-up assistance.

The thrust of this historic piece of legislation, as revealed in the Congressional Committee reports issued at the time the legislation was to be considered by Congress, is two-fold: to provide financial assistance to medical schools to assure their continuance as viable institutions, and at the same time, to increase the number of medical students.

The House of Representatives Committee on Interstate and Foreign Commerce in reporting its version of this legislation noted that

Table 4

FEDERAL OBLIGATIONS TO MEDICAL SCHOOLS, 1950-1973
(in millions of dollars)

Fiscal Years	Total	Undergraduate Medical Education						Graduate (Research) Training	Research Conduct 1/	Construction		Other Programs
		Total	Institutional Support			Student Assistance						
			Capitation Grants	Basic Support Grants	Special Project Grants	Scholarships	Loans			Teaching & Related Fac.	Res.Fac.	
1973	$1,017.7	$163.3	$102.2	-	$34.8	$6.8	$19.5	$125.5	$620.8	$28.2	$18.3	$ 61.6
1972	969.7	161.7	94.9	-	45.5	7.4	13.9	162.2	531.6	9.2	13.6	95.1
1971	874.3	97.3	-	21.8	55.2	7.1	13.2	160.5	440.6	97.5	. .	78.4
1970	813.6	71.9	-	21.3	34.9	7.3	8.4	165.8	392.1	108.7	. .	75.1
1969	814.6	60.4	-	21.1	19.8	5.3	14.2	168.2	414.3	93.4	5.8	72.5
1968	741.8	43.7	-	20.2	5.5	3.3	14.7	166.6	376.2	91.9	21.5	41.0
1967	688.2	34.8	-	18.8	. .	1.8	14.2	162.9	373.4	75.3	18.3	23.5
1966	557.6	16.4	-	6.6	. .	. .	9.8	126.1	335.2	48.8	31.1	
1965	500.5	6.6	-	. .	. .	. .	6.6	107.2	298.7	55.7	32.3	
1960	165.1	. .	-	. .	. .	. .	. .	41.5	106.4	3.4 2/	13.8	N.A.
1955	34.1	. .	-	. .	. .	. .	. .	6.0	26.9	1.2 2/	. .	
1950	19.9	. .	-	. .	. .	. .	. .	4.0	8.2	5.3 2/	2.4	

1/ Data for 1972 and 1973 only include grants and contracts for research; data for previous years do not include research contracts. Research contracts amounted to $60 million in fy 1972, and $79 million in fy 1973.

2/ Assistance for construction of hospitals owned by medical schools

Note: Program coverage for agencies of the Department of Health, Education, and Welfare may be considered to be complete except for payments for services provided to beneficiaries under the Medicare and Medicaid programs; for other federal agencies the data include only the obligations for conduct of research.

Source: Department of Health Education and Welfare, National Institutes of Health (Office of Resources Analysis Program Planning and Evaluation) and Bureau of Health Resources Development.

"if the serious shortages of health personnel are to be alleviated, it is imperative that the essential viability of the health professions schools be maintained" 7/

7/ House Report No. 92-258, 92 Congress, 1st Session, (1971) p. 27

The Committee emphasized that it -

"endeavored to find a meaningful mechanism of assistance to these schools which would serve to alleviate financial distress and provide a stabilizing basis for their educational program. The capitation levels proposed in this bill are designed to significantly alleviate the financial distress of those schools which are in serious financial straits. 8/Grants should enhance the ability of schools more fortunately situated to increase enrollments and make their curricula increasingly relevant to the health care needs of the Nation. The capitation grants are designed to provide a dependable support base for the educational programs of the health professional schools without having to go through the 'back door' of research to support education. Special project assistance authorized elsewhere in the bill would provide additional assistance to those institutions which will respond further to the Nation's complex health manpower needs." 9/

8/ The effectiveness of the capitation grant awards provided in the 1971 legislation to overcome the financial distress situation of medical schools is evident from the fact that prior to the new legislation, about 60 medical schools received awards to alleviate their financial condition in each of the fiscal years 1969,1970, and 1971; the number of such awards dropped to six for each of the fiscal years 1972 and 1973.

9/ House Report, p. 28

Significantly, however, the House Committee added that it had

> "weighed carefully the proposal of the Administration, the Association of American Medical Colleges, and others testifying before the Subcommittee, not to include an expansion of enrollment requirement as a condition for receipt of capitation grants. Although the proposal might have merit if only small amounts of Federal assistance were involved, the Committee feels strongly that if schools are to receive assistance of the magnitude proposed in this bill there should be results- -there should be increased manpower. The capitation grants will give the schools hundreds of thousands of dollars--and in some cases millions of flexible funds to be used at their own discretion to meet their educational needs. 10/

10/ House Report, p.29

The Senate Committee on Labor and Public Welfare, in reporting the Senate version of this manpower legislation made statements similar to those made by the House of Representatives Committee in respect to the basic financial problems to be overcome -

> "It is the Committee's conviction that the current financial crisis among health professions educational institutions precludes effective action on their part in response to these national needs. These institutions can and will respond to these needs only if they are assured of a predictable amount of Federal funds sufficient to stabilize their finances--and assure that education remains within financial reach of the student without forcing the school to the point of financial disaster. "
> " - - -The bill therefore entitles each educational institution to an award intended to cover approximately one-third of the average per student educational costs incurred nationally by such institutions - - - To the extent essential for the education of the students - - - the costs of research and the costs of patient care are integral to per student costs of the institution. And that they shall be included in the calculation of costs for the purpose of applying for the entitlement grant." 11/

11/ Senate Report No. 92-251, 92nd Congress, 1st Session, (1971) p.16

The Senate also reflected concern over the cost of professional education and the appropriate Federal share -

> "The Committee fully recognizes that the schools derive their

> resources to carry out their responsibilities from a variety of sources including State and local funds, private sources, philanthropy, tuition and fees for services, as well as Federal grants. Expenditures of the schools and the costs attributable to the education of students vary among the different schools within a discipline and among the disciplines. - - -
> - - - While it is undeniably the case that the health professional schools of the Nation are in varying degrees of distress, it is also true that the vast majority of them are in great financial difficulty. The bill, therefore, provides a mechanism of institutional support for schools of the health professions that recognizes a Federal responsibility for the support of these institutions that is shared with other public and private agencies and individuals in assuring continuing support of sufficient magnitude to enable the schools to carry out their educational responsibilities effectively and on the basis of sound planning and operation. 12/

12/ Senate Report, p. 17

Thus it appears that the current legislation reflects this national objective, and that the Nation, as a whole, through the Federal Government, accepts a share of the burden of supporting the necessary educational process, and thereby a role in maintaining the viability and stability of the institutions involved.

The Role of State Governments
In Undergraduate Medical Education

Publicly-owned medical schools receive a substantial portion of the funds they require for their over-all activities in

education and community services through the general appropriation process of the states. These state appropriations have increased from $60 million in 1960-61 to $255 million in 1971-72. For the past decade, however, the proportion of state funds to total operating expenditures (excluding sponsored activities) has remained constant at 55 percent.

Generally, the appropriation process does not provide an activity distribution of the funds appropriated. From the available information in the cost allocation studies, the Committee estimates that roughly 25-30 percent of state appropriations, in the aggregate, may help fund the undergraduate medical education program in public medical schools.

For the 1971-72 school year several states provided in the aggregate, an additional $29 million as subsidies to private medical schools, with the payment calculated on a per student basis. The usual requirement governing the receipt of the grant is that enrollment be increased, but not every state awarding these funds requires that the increase be limited to the residents of the state.

While the states have made available substantial funds to medical schools, when compared with the population of these states, and the personal income of the state residents, the support appears to be nominal. State funds for all activities of the medical schools amount to less than $2 per capita for 28 states; ten states provide amounts greater than $2 per capita, but less than $3; one state provides more than $3 per capita.

In relation to the personal income of the states' population, the amounts made available by 29 states is less than $5 per $10,000 of personal income; for 7 states, more than $5 but less than $6; 3 states provide more than $6 per $10,000 personal income.

Committee Recommendations for Financing Undergraduate Medical Education

It has now become an accepted national objective that access to health care is a right. To sustain that right, the training of the required health personnel must also be a national objective. And in this perspective, the institutions providing for health professions education must be deemed as vital national assets to be cultivated and sustained by virtue of their innate and critical value to the attainment of the national purposes in health.

It is against this background of national policy that the following recommendations are offered on the financing of undergraduate medical education.

The Committee believes that -

(1). The costs of undergraduate medical education should be shared by all who benefit from the education and

training of physicians -- the Federal and state governments acting for society, the students, and the private sector.

(2). Multiple sources of support for academic medical centers are preferable to a single source of support to help assure continuing diversity among the educational institutions and to assure their greater responsiveness to changing national needs and priorities.

(3). The current differential in sources of support for public and private schools will have to be continued. This is due in part to political realities related to difficulties in providing different levels of Federal support or in providing the same levels of state support for the two types of institutions. Both types of institutions provide differing sources of strength to undergraduate medical education, contributing in different ways to a high level of innovation in education, research and service.

(4). Adequate support must be provided for the biomedical research and service programs of all medical schools. These activities are not only critical to the advancement of the Nation's health but are necessary ingredients of all educational programs in the health professions. The interrelationships and interdependence of all the activities of modern medical schools require that the institutions be maintained as entities; adequate support for educational programs alone does not assure their continued viability.

(5). Qualified students of both sexes from all racial groups and socioeconomic levels should have equal opportunities for careers in medicine. Support through nonrepayable grants and loans from multiple sources should be adequate to remove financial considerations from the student's choice of the institution for his medical education.

(6). The student who receives financial assistance to enable him or her to pursue a medical career should not be unconditionally obligated to repay that assistance by a period of service in a designated area or designated professional specialty; the option to do so should remain with the student.

The Committee recommends the following sources of support for the undergraduate medical education program, excluding that portion of the full resource cost now met through contributed services, or from sponsored research or other income.

(1). Federal

A. The Federal government should provide one-third of the net cost of the undergraduate medical education program through grants to medical schools related to enrollment to provide a stable source of support for their basic operating programs. Special assistance should also be provided to

attain specific national health manpower goals such as curriculum innovations, better distribution of physicians geographically, or better distribution among specialties. There should be no differentiation between public and private schools with regard to this form of Federal support; both types of institutions are National resources, providing important contributions to the improvement of health with no regard to state boundaries. Loan and scholarship levels high enough to reflect the full cost of medical education would require the student to bear the full costs of all benefits and would be counter to the established philosophy of public support of higher education.

B. The Federal government should continue the present system of nonrepayable grants and loans for support of students, but the present ceiling on loans and scholarships should be increased to $4,500 per student, per year, to reflect the rising costs to the students of pursuing a career in medicine. The student assistance program should be administered by the medical school's financial aid officers. Their more complete knowledge of the financial status of the students and their ability to make optimal use of various forms of support, including employment to provide some income assure the most effective use of the Federal support provided. The scholarship and loan programs should, therefore, remain separate from the Federal support provided for [redacted]baccalaureate programs. The Office of Education is not knowledgeable about the special situations involved in supporting medical students. In addition, many students have exhausted their entitlement to Office of Education loans and scholarships during their baccalaureate education.

The total amount of support and the limits of support for a student should reflect the established needs and changing costs of the educational program. Furthermore, the amount of the assistance made available and its distribution between nonrepayable grants and loans should take into account the individual student's other fiscal resources.

There is adequate evidence that guaranteed loans, even with interest subsidy, are not available in adequate amounts to support medical students, particularly those from low income families. The present loan program is expected to become more nearly self-supporting as repayments are made and require smaller annual additions from Federal funds.

(2). State Support

A. State governments should continue to provide a sustantial portion of the funds necessary to meet the operating costs of the publicly controlled medical schools not funded by other sources - such as the Federal contribution, payments by students, or service income. State governments have the responsibility to provide the additional essential support to enable the public medical schools to meet their total objectives in education, research, and health care, and to maintain their financial stability.

While the state governments have a greater responsibility for the support of the public medical schools, they also have a responsibility for the support of private institutions. Private medical schools not only offer opportunities for the education of state residents, but provide many of the other benefits to the state made by the public schools. The available evidence indicates that two out of five graduates of private medical schools practice in the state where they receive their undergraduate medical education. This is less than the three out of five graduates of public medical schools who remain in the state but these private school graduates still constitute a substantial contribution to the physician supply in the state. Private schools are finding it increasingly difficult to remain financially viable and present state support has been critical to the survival of many of them. For a state to take over a private school or to replace the contributions of the private school to the state would exceed the cost of the level of state support proposed. To maintain the special contributions that private medical schools can make, the support should not establish such requirements on the schools that would, in essence, convert them to public schools.

B. States should continue to provide support through scholarships and loans for students to meet the particular needs of the students enrolled in the medical schools in the state.

3. Institutional Share

Both public and private medical schools should be able to cover some of the costs of medical education not covered from other sources by gifts and by allocating a share of the income produced by services provided by the institution. But this latter source of income should not be relied upon to the extent that it distorts the proper balance of medical school operations and their financing.

Technical Note

Methodology used in determining costs of the undergraduate medical education program not financed by contributed services, or by income from research or clinical activity

Contributed Services

The imputed value for goods and services included in the estimates of the full resource cost of the undergraduate medical education program were eliminated, as the first step, from the costs for all components of the educational process.

Research

The cost of the research essential for the undergraduate medical education program that must be financed as education was derived as follows:

The cost of the total research necessary for all education (undergraduate medical, house officers, MA and Ph.D. students) as determined by the model for the derivation of the full resource cost (see "Undergraduate Medical Education - Elements - Objectives - Costs", JME vol 49, No. 1, January 1974, pp 120-126), was subtracted from the cost of the total research program for each of the twelve medical schools studied by the committee. The remainder is the research activity not considered essential for educational programs. The income from federally sponsored research was first applied against the costs of this research effort. Any remaining federally sponsored research income was applied to the costs of the total research necessary for all education.

The costs of any unfunded research required for all educational programs was distributed in proportion to the costs of the research required for the education of undergraduate medical students, house officers, and MA, Ph.D. students.

The unfunded research necessary for the undergraduate medical education program for each of the 12 medical schools was then divided by the number of undergraduate medical students.

For those schools where the total research necessary for education as derived from the model exceeded the total research program all federally sponsored research income was assigned to the research costs necessary for all education.

Clinical Activity

The cost of the clinical activity essential for the undergraduate medical education program that must be financed as education was derived as follows:

The cost of the total clinical activity necessary for all education (undergraduate medical, house officers, MA and Ph.D. stduents) as determined by the model for the derivation of the full resource cost (see "Undergraduate Medical Education - Elements - Objectives - Costs", JME vol 49, No. 1, January 1974, pp 120-126), was subtracted from the total medical service expenses for each of the twelve medical schools studied by the committee.

The income to the medical school from the medical service provided by the faculty was first applied to the cost of the clinical activity in excess of the amount required for education. Any remaining medical service income was considered as income to fund the clinical activity necessary for education. This was distributed in proportion to the costs of the clinical activity essential for the education of undergraduate medical students, house officers, and MA, Ph.D. students.

The unfunded clinical activity necessary for the undergraduate medical education program for each of the twelve medical schools was then divided by the number of undergraduate medical students.

For those schools where the total clinical activity necessary for education, as derived from the model exceeded the total clinical activity program of the medical school, all of the clinical activity was considered to be necessary for education.

Action Item Consideration

Handout

AAMC POLICY STATEMENT ON NEW RESEARCH INSTITUTES AND TARGETED RESEARCH PROGRAMS

The Association of American Medical Colleges reaffirms its strong belief that a key element in the past and future success of our national effort to conquer disease is a strong, diverse, balanced program of high quality biomedical research. The present organizational structure of the National Institutes of Health, which encompasses disease categories, organ systems, basic science and the particular needs of the various age groups in our population, is satisfactory for all the perceived goals of the NIH. Therefore, the Association strongly believes that reorganization of the National Institutes of Health will not facilitate the conquest of the diseases of man. The Association recognizes the possible need to add new responsibilities to the existing programs of the various Institutes of the National Institutes of Health and the National Institute of Mental Health to accomplish new objectives which are not presently identified. However, the Association cannot endorse the further fragmentation of our national biomedical research effort by the establishment of additional institutes at the National Institutes of Health and the National Institute of Mental Health.

Legislative proposals which authorize the increased expenditure of funds for biomedical research programs directed toward specific disease entities do not necessarily increase the total funds available for our national biomedical research effort. In addition, these programs skew the balance of the entire NIH program and in certain instances may divert money from biomedical research to patient care.

The Association believes that an essential prerequisite for national programs targeted toward the conquest of specific diseases is the development of the basic knowledge upon which a targeted program can be built. Thus, it is essential that support for fundamental scientific research programs, such as those supported by the National Institute of General Medical Sciences, must be maintained. Targeted programs which divert funds away from basic research will ultimately compromise our ability to achieve our long term national biomedical research goals.

The Association believes that the enactment of any new legislative proposals targeted toward the conquest of specific diseases should be predicated upon the following principles:

1. The basic scientific information must be available to provide a knowledge base upon which a targeted program directed toward the conquest of a specific disease can be built.

2. There should be a clear indication in the development and implementation of a specific legislative program that such a program shall not occur at the expense of other programs in our national biomedical research effort.

3. It must be clearly evident that existing programs and legislative authorities cannot be adapted to accomplish the goals of the proposed program.

Discussion Item

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

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

WASHINGTON: 202: 466-5175

June 13, 1974

MEMORANDUM

TO: AAMC Executive Council & Administrative Boards

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

SUBJECT: Proposed AMA Guidelines for Housestaff Contracts

Enclosed for discussion at the June meetings of the Administrative Boards and Executive Council are proposed AMA Guidelines for Housestaff Contracts. These guidelines have been approved by the AMA Board of Trustees and will be considered by the House of Delegates at their June meeting. The attached correspondence between Henry McIntosh and Jim Sammons provides some background on the subject.

Attachment

REPORT OF THE BOARD OF TRUSTEES

Report: P
(A-74)

Subject: Guidelines for Housestaff Contracts

Presented by: Richard E. Palmer, M. D., Chairman

Referred to: Reference Committee C
(James D. Murphy, M. D., Chairman)

At the 1973 Clinical Convention the House of Delegates referred Resolution 8 to the Board of Trustees and its Committee on Housestaff Affairs, the Intern and Resident Business Session, the Council on Medical Service and the Council on Medical Education. Resolution 8 called for development of principles and guidelines for agreements between housestaff and the institutions in which they serve, and exploration of the development of a model contract.

Attached are guidelines which catalogue options which are appropriate for discussion between housestaff and the respective institution and are submitted for the information of the House of Delegates.

Past House Action: C-73:228

GUIDELINES FOR HOUSESTAFF CONTRACTS

I. Introduction

This is an outline of basic principles to be applied to contracts between Housestaff and the institution at which they serve. There are so many variables present from training institution to training institution that no single form of contract would be helpful. The AMA has therefore developed a set of guidelines for the more important substantive provisions of a Housestaff contract.

The subjects here included are not intended as the only subjects of importance for a contract or appropriate for every contract. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: a collective bargaining contract (which is recommended); uniform individual contracts; or as part of the rules of government of the institution. In each instance, it will be necessary for the Housestaff Association to evaluate its needs and the ability of the institution to fulfill them and then establish Housestaff priorities and bargain accordingly with the institution.

II. Proposed Terms and Conditions

A. Parties to the Agreement

The representative status of the Housestaff Association should be expressly accepted and recognized in the contract.

The contract may be between a Housestaff Association with members in several institutions, and a group of related institutions (such as all city hospitals in a certain city), or it may be between a Housestaff Association and a single institution.

Position, salary and all other benefits should remain in effect without regard to rotational assignments, even if they are away from the parent institution.

The agreement should provide coverage for all those performing the duties of interns, residents and fellows. Particular care should be taken to protect against the practice of unpaid "volunteers" performing such duties.

Individual Housestaff Officer contracts should be required to be consistent with the principal contract.

Adequate prior notification of the institution's intention not to renew an individual's contract should be required so that the Housestaff Officer will have sufficient time to obtain another appointment.

B. Obligation of the Institution

The institution should agree to:

provide a training program which meets the standards of the Essentials of Approved Residencies of the AMA;

continuously maintain its staff and its facilities in compliance with all of the standards of the Essentials of Approved Residencies;

proscribe increasing the pyramidal nature of the training program during the tenure of persons already in or accepted to that program.

C. Obligation of Housestaff

Housestaff members should agree to fulfill the educational requirements of the residency program, and to use their efforts to provide safe and effective patient care as assigned or required under the circumstances.

Housestaff Members should comply with the laws, regulations and policies to which the institution is subject.

D. Salary of Housestaff

The salary to be paid to each level of Housestaff, and the day of the payment should be specified. If there are to be progressive increases, the basis for the increase should be specified, together with the time when such increases are to take effect.

In determining the salary level of a Housestaff Officer, credit should be provided for prior training experience where a House Officer has shifted from one program or institution to another.

A specific salary differential should be provided for chief residents or their equivalent.

Specific salary differentials may be provided where appropriate in particular services.

E. Hours of Work

There should be a recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call scheduling are not consistent with the primary objective of education or the efficient delivery of optimum patient care. The institution should commit itself to fair scheduling duty time for all Housestaff members, as well as the provision of adequate and defined off duty hours.

F. Off Duty Activities

This is an appropriate topic for collective bargaining between the Housestaff Association and the institution; and the results of the bargaining on this subject should be clearly set forth in the agreement. The contract could provide that a Housestaff Officer is free to use his off-duty hours as he sees fit, including engaging in outside employment so long as such activity does not interfere with obligations of the Housestaff member to the institution or to the effectiveness of the educational program he is pursuing.

G. Vacations and Leave

The amount of vacation, sick-leave and educational leave to which each Housestaff member is entitled should be specified.

Vacation should be expressed in terms of customary working days as defined by the Institution.

If vacations may be taken only at certain times of the year, this should be expressed. Any requirements for scheduling vacation time also should be stated.

Leave provision may also cover maternity, paternity, bereavement, military duty examinations, preparations therefor, and educational conference purposes. Reimbursements for tuition and expenses incurred at educational conferences should be considered.

The agreement should set forth any progressive increases in the amount of time allowed for vacations, sick leave and educational leave.

Educational leave should not be deducted from vacation time.

H. Insurance Benefits

The insurance benefits which were negotiated should be set forth with particularity and should be tailored to the specific needs of Housestaff Officers.

Some of the more common insurance benefit provisions are (a) hospitalization and basic medical coverage for the Housestaff member and spouse and minor children; (b) Major Medical coverage for Housestaff members and family; and (c) group life insurance, and dismemberment and disability insurance for the Housestaff member only.

It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the Housestaff member. Co-paid benefits should be established, separately from other hospital employee benefits, as a means of maximizing benefits.

In some instances, free care for Housestaff Officers and their families at the training institutions may be provided.

In lieu of insurance benefits, the contract may provide for fixed annual payments to the Housestaff Association for each Housestaff Officer so that the Housestaff Association may determine and provide for insurance or other benefits for Housestaff Officers.

I. Professional Liability Insurance

The contract should specify the amount of Professional Liability Insurance which the institution will provide for each Housestaff member, together with the limits of liability applicable to such coverage.

It might also be appropriate to provide in the contract that the Housestaff members and the institution will fully cooperate with the insurance company in the handling of any professional liability claim.

J. Committee Participation

In so far as possible, the institution should agree to provide for appropriate participation by Housestaff members on the various Committees within the institution. This participation should be on Committees concerning institutional professional and administrative matters. Members should have full voting rights. Housestaff members should be selected by the Housestaff Association members themselves.

K. Grievance Procedures

The contract should provide a grievance procedure. That procedure typically involves the following:

1 - a definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice);

2 - timing and sequence of the grievance steps (initial steps referred to the chief of service, then to the medical board or administrator as a review body);

3 - a right to legal and other representation at each step for the Housestaff Officer;

4 - the right of the Housestaff Association independently to initiate and process a grievance;

5 - a final step - binding arbitration to be initiated only by the Housestaff Association; and

6 - sharing of arbitration costs.

L. Disciplinary Hearings and Procedure

The contract should provide a disciplinary procedure which guarantees "due process" before any disciplinary action is taken against a Housestaff member. Attachment A provides a procedure which may be appropriate or modified for use in a given institution. The procedure adopted should be set forth in full in the contract between the institution and Housestaff Association.

M. Working Conditions and Patient Care Issues

The agreement should provide for adequate, comfortable, safe and sanitary facilities such as on-call rooms, secure storage areas, security personnel, facilities for books, storage of clothing, comfortable sleeping quarters, and limitation of the number of beds per room.

There should be proscription against regular and recurrent performance of duties by Housestaff Officers unrelated to Housestaff Officer training.

Patient care issues, educational training, and salary are compensations for work and are negotiable.

In so far as patient care issues are described in terms of reference to the physician's job description, these frequently fall under contract working conditions.

The quality of patient care services and facilities may be a specified feature of the training program contract, and can include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.

N. Other Provisions

As indicated, the foregoing provisions are not all-inclusive. Depending upon the institution's size, location and affiliations, if any, and also depending upon the relationship between the institution and the Housestaff Association, other provisions may be included. For example:

payroll deduction of Housestaff dues;

agency dues in those jurisdictions where authorized;

maintenance of existing benefits and practices not otherwise expressly covered;

housing, meals, laundry, uniforms, living out and telephone allowances;

adequate Housestaff Association office space, bulletin boards, secretarial assistance;

Housestaff Association seminars or meetings; and

Housestaff renewal or negotiation of the contract at the end of the term.

III. Legal Assistance

The process of collective bargaining and drafting a contract which will effectively reflect the result of such bargaining will involve many legal considerations. The Housestaff should consider retaining legal counsel to advise and represent them on those matters.

ATTACHMENT A

DISCIPLINARY HEARING AND PROCEDURE

1 - Before any Housestaff member may be reprimanded, suspended, expelled, or suffer a denial of any right or privilege due by virtue of his appointment as a Housestaff member or under any provision of this agreement, said Housestaff member shall be entitled to the benefits of the procedures and appeals provided in this article.

2 - Action seeking to reprimand, suspend, expel, or to deny to any Housestaff member a right or privilege shall be commenced by the preparation of a complaint in writing setting forth the conduct complained of and the requested penalty. This complaint shall be filed with the Disciplinary Committee and a true copy shall be delivered personally to the Housestaff member complained of.

3 - The Disciplinary Committee shall appoint a Hearing Committee consisting of physicians - 40% o f whom are Housestaff Officers to be selected by the Housestaff Association or the Housestaff Officers if there is no Housestaff Association. No member of the Hearing Committee shall be personally involved in the controversy described by the complaint. It shall be the duty of the Hearing Committee to conduct a fair and impartial hearing, pursuant to the provisions of this article and such further rules of procedure as the Committee may adopt for each hearing, which shall not be inconsistent with the provisions of this article.

4 - The Hearing Committee shall set a time and place for a hearing on the complaint, which shall allow the accused Housestaff Officer a reasonable period of time to prepare his defense. The Hearing Committee may extend the time for the hearing by agreement of the parties or as the Hearing Committee may determine.

5 - The accused Housestaff member shall not be required to file a formal written defense to the complaint. The accused Housestaff member may ask the Hearing Committee to order the Complainant to make the complaint more specific by pointing out, in a written request filed with the Hearing Committee and served on the complainant, wherein the complaint is vague or ambiguous. If the Hearing Committee so orders, a more specific complaint must be promptly filed and served on the accused Housestaff member.

6 - Formal rules of evidence shall not prevail at the hearing conducted by the Hearing Committee; however, all evidence offered and considered at the hearing must be reasonably related to the facts and statements contained in the complaint. Both parties may be represented by attorneys or by physicians of their choice at all stages of the procedure. No evidence shall be offered or considered by the Hearing Committee at any time except at a duly convened meeting of the Hearing Committee and while the accused Housestaff member is present.

7 - The accused Housestaff member shall not be obligated to present any evidence by way of defense until the complainant has presented all of the

evidence in support of the complaint. The accused Housestaff member shall not be compelled to be a witness against himself, but shall be given a reasonable opportunity and a sufficient period of time in which to present evidence in support of the defense. Immediately thereafter, the complainant shall be given an opportunity to rebut the Housestaff member's evidence but not to offer new evidence which could have been presented previously.

8 - After hearing all of the evidence, the Hearing Committee shall meet and decide if the evidence offered supports the complaint. If 75% or more of the Hearing Committee shall join in a decision they shall prepare a formal written document entitled "Findings of Fact" in which they state that the allegations of the complaint have or have not been proven and summarize the evidence in support of that finding. This document shall be filed with the Disciplinary Committee and a copy shall be delivered to both parties. If the Hearing Committee finds that the complaint has not been proven, no further action shall be taken on the same facts or occurrence. If the Hearing Committee finds that the complaint has been proven, the Housestaff member shall have the right to appeal as provided below. If the Hearing Committee is unable to reach a decision as aforesaid, they shall so report and no further action shall be taken, but such decision shall not preclude a subsequent complaint on the same charge provided that additional evidence not previously available shall be offered in support of the complaint.

9 - If the Hearing Committee has found the complaint to be proven, the accused Housestaff member shall be entitled to appeal the decision to the full Disciplinary Committee. The accused Housestaff member shall request an appellate hearing in writing and shall serve a copy of the request on the complainant.

10 - A verbatim transcript of the proceedings before the Hearing Committee shall be prepared and filed with the Disciplinary Committee before the appellate hearing shall be convened. Each party also shall have the right to file a written argument with the Disciplinary Committee before the hearing date. A copy of any written argument shall be served on the other party. At the appellate hearing, both parties shall have an equal amount of time for oral argument. No additional evidence shall be offered at the appellate hearing. The Disciplinary Committee shall confine its considerations of the appeal to the records before the Hearing Committee and the appellate argument.

11 - The concurrence of 75% of the members of the Disciplinary Committee shall be required to affirm the decision of the Hearing Committee. Upon such concurrence, the Disciplinary Committee shall report its findings in writing to the Directors of the Institution, together with a recommendation for punishment or penalty to be imposed. A copy of such report shall be delivered to both parties. If the Disciplinary Committee shall not have the concurrence of 75% of its members in any decision, the matter shall be disposed of without further action upon filing the report of the Disciplinary Committee.

12 - Upon receiving the report of affirmance by the Disciplinary Committee and the recommendation of the Committee as to penalty or punishment, the Directors or their delegate(s) may impose punishment or penalty on the Housestaff member, but not in excess of that recommended by the Disciplinary Committee.

13 - No Housestaff member shall be subjected to any disciplinary action or penalty or loss of any compensation until completion of these procedures; provided, however, that a Housestaff member may be suspended, but with pay, pending hearing and appeal where such suspension shall be required by substantial and imminent considerations of patient care.

14 - The contract could provide as a final step in the disciplinary proceedings binding arbitration by a neutral medical expert, mutually selected.

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

AMMONS, M.D.
President Designate
6202)

May 23, 1974

Henry D. McIntosh, M. D.
Chairman, Department of Medicine
Baylor College of Medicine
Texas Medical Center
Houston, Texas 77025

Dear Henry:

I have deliberately not responded to your letter of April 18 until now in order to be able to give you some positive answers to the questions that you raised.

Let me tell you what the present status of the Guidelines for Housestaff Relationships to Teaching Institutions is. First of all, the Board of Trustees, at its meeting in April, approved these Guidelines for transmission to the House of Delegates, at which time, in June, they will be referred to the appropriate reference committee of the House where general discussion and debate, both pro and con, will occur. Following said debate, the reference committee will then make a recommendation to the House to either approve, disapprove, amend or table this document. Frankly, I understand the problems that you present in terms of Baylor's particular situation; however, in all candor, I must also acknowledge that there are teaching institutions in the country in which some form of due process must be instituted if the training programs are to continue to survive because of activities that have occurred over the past several years. Happily, this does not refer to Baylor.

I am aware that all Housestaff situations are different, and particularly in terms of Baylor's relationship with the hospital district, the VA, the Methodist, and St. Luke's, and I also am aware that certainly this committee can "create many problems" but at the same time, I think we must all acknowledge that at the moment, since they are in excess of 50,000 in training programs across the country, that some sort of guidelines for at least reasonable stability is indicated.

I do not know what the response of the AMA House will be; however, I would encourage you to appear before the reference committee here in Chicago during the course of the Annual Convention to present the point of view which you have enunciated in your letter, and also to review the Guidelines that the Board is referring for study. In order to help you with that evaluation, I am enclosing a copy of the Board report which includes a "due process" procedure.

Insofar as your comments relative to the National Society for Medical Research are concerned, I am just now getting into the problem of NSMR and will be in a better position to respond the next time I see you. At the moment, I must confess that I am not very familiar with this organization.

Sorry that I missed you during the course of the Texas Medical Association meeting; however, I am glad that Russ and I had breakfast with Joe Merrill, and felt it was very productive.

Best personal regards,

James H. Sammons, M. D.

Enclosure

BAYLOR COLLEGE OF MEDICINE
TEXAS MEDICAL CENTER
HOUSTON, TEXAS 77025

DEPT. OF INTERNAL MEDICINE
(713) 520-4951

May 30, 1973

James H. Sammons, M.D.
Executive Vice President Designate
American Medical Association
535 Dearborn Street
Chicago, Illinois 60610

Dear Jim:

Your letter of May 23 with the present status of the Guidelines for House-staff Relationships to Teaching Institutions was received. To say the least I am amazed. I cannot understand how a resolution of this type, if that be what it is called, could have been formulated and approved by the House of Delegates to be referred to the Board of Trustees and its Committee on House Staff Affairs and then get back to the House of Delegates. This resolution for all intents and purposes makes a hospital which offers an educational experience and pays salary for it enter into collective bargaining with an organization that cannot police its own ranks, cannot be responsible for recruiting and contributing to the long-term solvency and strength of the institution.

Our House Officers Association has in the past elected its officers with but a handful of members present. We have 540 or more house officers. Even after the House Staff Organization sent out notices (see enclosure), posted notices on bulletin boards, etc., urging wives as well as house officers to come and bring their children to discuss salaries and vacations, with George Jordan and myself mentioned by name as being opposed to the house staff, only about 100 attended the meeting. Yet, this document states on page 2, line 24 and 25, "The representative status of the Housestaff Association should be expressly accepted and recognized in the contract."

The document reads like some of the PSRO and Medicare legislations that you have opposed so violently because they interfere with the internal workings of the physician and his hospital staff. It seems that the AMA is encouraging and in fact propagating such similar restrictive and unnecessary, in many sectors, legislation.

The AMA House of Delegates as well as the leadership by this action is deciding that they want American medicine to be unionized ten years from now.

As one trains young people during their formative period of life, so will they function in later years. It is inconceivable that the AMA could expect a house officer to participate actively in collective bargaining on a nationwide basis, albeit salaries, etc. may vary from institution to institution (but not for long), and not expect that these same doctors ten years from now will be negotiating with their hospitals and other agencies through collective bargaining. Maybe this is a part of the grand plan. I urge that serious thought be given to what effect this type of activity will have on the future doctors. It would seem to me that this will deprofessionalize the profession as much as anything I have seen.

Maybe it is thought that the profession should become a union, if so, I think the leadership should speak out to this point. I have no objection to setting up guidelines. But I do think that it is wrong to indicate that these guidelines relate to an organization who is constantly changing and by the mere nature of the activities of the potential members attracts only a relatively small vocal few.

I have been intimately associated with house officers for twenty odd years and have personally visited many programs. I interview countless house officer candidates each year. I do not believe that the "picture" that has apparently been given by the leaders of the Housestaff Association is representative. My concerns are not based only on the experience with programs here at Baylor.

I would like to know when this matter will be brought to the reference committee and how I can arrange to testify.

Sincerely,

Henry D. McIntosh, M.D.
The Bob and Vivian Smith Professor,
and Chief of the Medical Service,
The Methodist Hospital, and
Chairman, Department of Medicine,
Baylor College of Medicine

HDM:sd

May 31, 1974

OFFICE OF THE PRESIDENT
Please Reply To:
The Methodist Hospital
6516 Bertner Boulevard
Houston, Texas 77025

Executive Committee
American College of Cardiology

You will find enclosed a letter from James Sammons of the AMA to me in reply to my letter to him regarding clarification of the rumor that we had heard that the AMA was supporting the collective bargaining of house officers throughout the country in a unified fashion. My first concerns were aroused by the article in the AMA News indicating that this was under study and that the AMA was interested in tying in "compulsory membership" in the AMA with the agreement to support the unionization. (I guess the better term would be collective bargaining). Jim Sammons, surprisingly, seems to favor such a move. If one questions why, it is not difficult to imagine that dues of say $50.00 a year as a house officer member of the AMA for 50,000 people would be $2,500,000 per year, and a large part of the 50,000 might continue their membership for life.

I ask you to read carefully the guidelines that have been prepared for house staff contracts by the AMA and realize that this will be discussed in committee at the AMA meeting in Chicago on June 24th.

I have two concerns about this matter:

1. As the chairman of the department of medicine, I am not certain this is the way to create an environment in which one can train house officers to become compassionate and competent physicians. This may or may not be of concern to the membership of the College.

2. Of even more importance is the fact that as one trains a young person and creates a life style, one can be certain that this will be prepetuated through life. It would seem to me that if it was agreed that the medical profession should be unionized ten years from now, there would be no better way to do this. I believe that

the AMA is being very short sighted in not apparently showing concern over what is the long term implication of collective bargaining on a nationwide basis for physicians in training. Having grown accustomed to this way of living, it hardly seems likely that a doctor, once he completes his training, will give up such a "life style."

I believe that we are looking at a situation which can have a profound effect on the medical profession over the next decade and from then on, and will determine the attitudes of the public to physicians. It is possible that this is what the vast majority of physicians want. If so, I think that we should give careful thought to the matter before instituting it.

Therefore, I think that the College should be concerned about this action. I believe that the College should take a stand that we are aware of the plans. We are aware that some house officers may not have had an ideal type of environment in which to learn and might have had to work extra hours, and so on. We, however, feel that anything with such profound long range implications should be entered into cautiously. I believe that the College should urge a period of thoughtful reflection over a year or so. I would think that the membership of the College would support such a decision.

I have discussed this with Charles Fisch and with Bill Nelligan. Would you please reflect on this matter and give me a call within the next week?

Sincerely,

Henry D. McIntosh, M.D.
President
American College of Cardiology

HDM:hc
Encls.

Action Item A - corrected page 3

DEVELOPING SCHOOLS (Schools progressing from Provisional status to fully developed schools)

	DATE OF SURVEY	YEARS APPROVED
Mayo Medical School	10/10-12/73	Continued provisional approval pending survey visit in Fall, 1975.
College of Medicine & Dentistry of New Jersey Rutgers Medical School	11/26-30/73	LCME voted to delay action until its June meeting at which time a progress report will have been received.

CONVERSION FROM TWO-YEAR TO FOUR-YEAR MEDICAL SCHOOL

University of North Dakota School of Medicine	10/23-26/73	Continued full accreditation for the School of Basic Medical Sciences until 1977. Provisional accreditation as an M.D.-degree-granting institution.

REQUEST FOR LETTER OF REASONABLE ASSURANCE

Texas A & M University/ Baylor College of Medicine	2/4-6/74	The LCME voted against issuing a Letter of Reasonable Assurance and against granting provisional accreditation.

* years from date of survey

Action Item B - Correction

ELECTION OF INSTITUTIONAL MEMBERS

The following medical schools have received full accreditation by the Liaison Committee on Medical Education, have graduated a class of students and are eligible for full Institutional Membership in the AAMC:

1. University of Massachusetts
   Worcester

2. State University of New York at
   Stony Brook Medical School

3. Texas Tech University
   School of Medicine

4. University of Texas Medical School
   at Houston

COD-COTH-CAS JOINT MEETING
NOVEMBER 13, 1974

AAMC ANNUAL MEETING
NOVEMBER 12-16, 1974
CHICAGO, ILLINOIS

INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION: ISSUES AND ANSWERS?

2:00 - 3:30 p.m. Policies for the allocation of medical center resources and facilities for graduate medical education: What is at stake?

2:00 - 2:20	The Hospital Administrator's Perspective
2:20 - 2:40	The Dean's Perspective
2:40 - 3:05	The Faculty's Point of View
3:05 - 3:30	Discussion (Moderator and the three speakers lead discussion which is open to the floor.)

This section of the program is designed to lay out the organizational, educational and financing issues from the varying perspectives of those within the medical center who play key roles in graduate medical education and upon whom the success of any move toward institutional responsibility will depend. Questions to be addressed include: How will priorities be set and resources allocated? By whom? Through what organizational framework? Where will the resources be derived? And at what cost?

3:30 - 3:45 p.m. COFFEE BREAK

3:45 - 4:30 p.m. Qualitative and quantitative assessment: Who calls the shots?

3:45 - 4:05	How should the number of residents in each specialty be controlled and by whom?
4:05 - 4:25	How can genuine educational quality be ensured?
4:25 - 4:45	Student Selection - The issues of quality and continuity in the transition to the graduate phase.
4:45 - 5:05	How should responsibility for financing graduate medical education be assigned?
5:05	Discussion

This section of the program will deal with supra-institutional issues, or those which may involve the operation of national bodies or national level cooperation among the institutions. Questions to be addressed include: Should there be a national system for allocating specialty training positions? If so, is this a governmental or a non-governmental function? What is the appropriate configuration for such a body? On what basis should such decisions be made? What is the role of external assessment procedures, accreditation, PSRO's? Who sets standards of quality and how? Is there any necessity for a national system for facilitating student (resident) selection? How should it best be operated? Should a qualifying exam be instituted at the undergraduate-graduate interface? The financing issue would be approached from the standpoint of national long range policy.

Discussion Item

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

June 20, 1974

M E M O R A N D U M

TO: COD, CAS and COTH Administrative Boards

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

SUBJECT: Proposed Workshop on the Ethical Aspects of Medical Care

Enclosed please find a preliminary agenda for a proposed workshop jointly sponsored by the AAMC and the National Academy of Sciences which is planned for September 18, 1974. It is proposed to invite the administrative boards of our three Councils, individuals from the Liaison Committee on Medical Education and selected AAMC staff to participate in this one day workshop which will be held at the NAS.

The proposed program is presented to you for comment and an expression of your interest in participating in this program on Wednesday, September 18, the day before the September, 1974 administrative board meetings.

One problem which should be considered before endorsing the program is that Tuesday, September 17 is Rosh Hashana. Certain of our Jewish colleagues may not be able to participate because of this conflict. The next possible date for the proposed program would be prior to the March, 1975 administrative board meetings.

Attachment

TENTATIVE AGENDA

WORKSHOP ON THE ETHICS OF MEDICAL CARE

National Academy of Sciences

September 18, 1974

Moderator: Bernard Towers, M.B., Ch.B.
Professor of Pediatrics and Anatomy
University of California, Los Angeles

I. Overview of Educational Objectives - 9:30 a.m.

Bernard Towers, M.B., Ch.B.
Professor of Pediatrics and Anatomy
University of California, Los Angeles

This presentation will focus on the educational objectives that are to be achieved in the teaching of ethical issues involving medical care. To accomplish this, the areas of traditional medical ethics -- the value problems that emerge in the individualized physician-patient relationship -- will be discussed with the idea of showing how these issues are related to the broader social justice issues concerning the distribution of medical services.

II. Justice Issues of Resource Allocation in Health Care - 10:50 a.m.

Roger J. Bulger, M.D.
Executive Officer
Institute of Medicine

The justice issues of how money and resources should be allocated in health care is of particular importance now with the potential development of a national health insurance system. This topic will deal with the concept of the preciousness of life from the standpoint of government decision making. It might include an analysis of the implications of the recent passage of the provision

in the Social Security Amendments which cover treatment of end-stage renal disease. In selecting one category of disease, what happens to those who are suffering from other conditions which may also be very expensive and require life-saving technology? How are decisions made regarding government allocation programs and what are the value questions that should be elucidated when such decisions are being made?

12:10-1:30 p.m. - LUNCH

III. Ethics and Accountability in Medical Care - 1:30 p.m.

Kerr L. White, M.D.
Professor of Medical Care and Hospitals
The Johns Hopkins University School
of Public Health and Hygiene

This topic will concern itself with the ethical responsibility of those participating in accreditation processes. Hospital committees such as tissue review and utilization committees as well as accreditation bodies at the JCAH and the Liaison Committee on Medical Education are empowered to assess and monitor various functions in the medical system. These committees receive their authority from society and therefore are invested with an ordering of responsibilities, not only to the providers of medical care but also to the consumers in the society in general. With the emergence of large-scale peer review through PSRO's, the issues surrounding the ethical responsibility of such monitoring groups becomes particularly important. The medical students of today are more and more likely to become participants in one way or another on such review committees.

IV. Ethical Assumptions of Various Care Settings - 2:50 p.m.

Richard Magraw, M.D.
President
Norfolk Area Medical Center Authority

The value assumptions of various settings for providing care to patients will be examined. The care settings, which range from the individual proprietorship or

fee-for-service medicine in a highly organized prepaid setting such as health maintenance organizations, affect considerably the way in which care is provided to consumers. Each of these settings creates its own incentives for the provider of care and thereby influences the benefits which are received by the patient. Inevitably some of the ethical considerations surrounding medical settings are related closely to those involved in decisions regarding resource allocation.

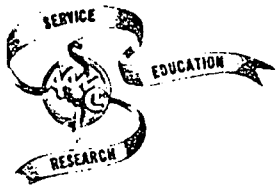
V. Existing Teaching Programs in Medical Ethics - 4:10 p.m.

E.A. Vastyan
Associate Professor and Chairman
Department of Humanities
College of Medicine
The Milton S. Hershey Medical Center
of the Pennsylvania State University

This presentation will deal with an overview of some of the existing programs in the teaching of medical ethics. This overview will discuss not only the advantages but also the pitfalls and limitations of various programs.

Summary of Workshop - 5:20 p.m.

We will probably consider someone like Dr. Bernard Towers to chair the entire workshop and to present the summary at the end where he attempts to integrate the beginning statements pulled all together into a conceptual foundation and end with possibly the recommendation for a continuing effort between the Institute of Medicine and the Association of American Medical Colleges.



Discussion Item

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

June 20, 1974

M E M O R A N D U M

TO: CAS Administrative Board

FROM: Michael F. Ball, M.D., Director, Division of Biomedical Research

SUBJECT: Scholarly Activities and Medical School Faculty: A Historic Perspective

The attached document entitled "Scholarly Activities and Medical School Faculty: A Historic Perspective" has been prepared by the Biomedical Research Committee for presentation to Executive Council at its fall meeting. We would appreciate receiving your comments and criticisms.

Attachment

MFB:ms

SCHOLARLY ACTIVITIES AND MEDICAL SCHOOL FACULTY

A HISTORIC PERSPECTIVE

At the turn of this century physicians graduating from German universities were publicly acknowledged to be superior to those educated in any other country.[1,2] This excellence of German education reflected a unique characteristic of the German system of medical education which developed during the second half of the 19th century. In Germany a student studied medicine in a university medical school where teaching and investigation were regarded as equal factors in the formulation of medical education. The German university gave comparable emphasis to scientific investigation and to teaching, and eminence in research, as well as ability to teach, became the accepted basis for promotion at the university.

In reviewing the history of the evolution of German medical education, Abraham Flexner noted "How rapidly, once the fundamental importance of successful research to the ambitious teacher was established, the requisite facilities, clinical and laboratory, were obtained, and how rapidly differentiation and specialization took place."[2] Both basic scientists and clinicians aspiring to academic medicine were deliberately trained to be competent investigators. By 1910, German university medical schools had well-equipped and supported laboratories in each of the primary medical disciplines. In contrast, during the same period in the United States, poorly

trained doctors were being produced by proprietary schools unaffiliated with universities. Biomedical research and scholarly pursuit by the faculty were unknown. In his classical monograph on American medical education published in 1910, Abraham Flexner noted "Investigation and practice are thus method and object ... an exacting discipline cannot be imparted except in a keen atmosphere by men who are themselves in training. Of course the business of the medical school is the making of doctors; nine-tenths of its graduates will, as Dr. Osler holds, never be anything else. But practitioners of modern medicine must be alert, systematic, thorough, critically open-minded; they will get no such training from perfunctory teachers. Educationally, then, research is required of the medical faculty because only research will keep the teachers in condition. A non-productive school, conceivably up-to-date today, would be out-of-date tomorrow; its dead atmosphere would soon be careless and unenlightened dogmatism."[1] Flexner viewed medicine as a science in which no distinction can be made between research and practice, rather than as a classical art. In elaborating on this point, Flexner stated, "If medicine is classified as an art, in contradistinction to a science, the practitioner is encouraged to proceed with a clear conscience on superficial or empirical lines; if, on the other hand, he is acutely conscious of the responsibility to the scientific spirit and scientific method, he will almost inevitably endeavor to clarify his conceptions and to proceed more systematically in the accumulation of

data, the framing of hypothesis and the checking-up of results."[1]

It is impossible to over-emphasize the impact of Abraham Flexner on the evolution of the twentieth-century American medical school. At the time of completion of Mr. Flexner's studies, there were 23,927 students enrolled in 148 American medical schools. (Table 1) Over the next 15 years, 68 schools closed and the number of students enrolled decreased by more than 5,000. Medical education became a university discipline with finite educational standards. Teaching in the laboratory and the hospital became a central part of the process of medical education. The costs of these revolutions were high but many voluntary health organizations, philanthropic agencies and industrial firms contributed to help. Schools financed these additional responsibilities from large private gifts. In addition, state revenues began to be used to support medical education. Many schools made increasing efforts to support research and to appoint to their faculties productive scientists. The medical school faculty became our nation's biomedical research scientists and their salaries, equipment and supplies were paid for from the budget of the medical school. In 1932, for the first time, attention was called to the increasing research emphasis in the schools of medical education.[3] Particular concern was expressed about isolating medical research from the education of medical students. By 1941, 17 medical schools had research budgets in excess of $100,000 a year and research expenditures constituted 11% of the budgets of the schools, with 98% of the funds

for sponsored research derived from non-federal grants.[4] Coincident with the increase in university affiliation of the medical schools, there was a progressive trend to employ more medical school faculty on a full-time or a geographic full-time basis, particularly in the clinical departments. Teaching and research had become inseparably intertwined. In many schools the chief consideration in the selection of full-time faculty became proven research ability. By 1950, research expenditures constituted 32% of the expenditures of four-year medical schools.[4] Complaints about the over-emphasis on research became louder. As was indicated by one dean of a privately supported school, "There is over-emphasis on research. It is trite to say this because it has been reiterated ad nauseam, but the fact still remains that we do not place enough emphasis on teaching, nor do we compensate adequately for the capacity to teach. We give lip service constantly to the importance of teaching, but when the chips are down, research always tips the balance."[4] Medical school faculty seemed to have forgotten Abraham Flexner's balanced emphasis; "The truth is that an instructor, devoting part of his day under adequate protection to investigation, can teach even the elements of his subject along rigorously scientific lines. On the other hand, it will never happen that every professor in either the medical school or the university faculty is a generally productive scientist. There is room for men of another type -- the non-productive, assimilative teacher of wide learning, continuous receptivity, critical sense and responsive

interest. Not infrequently, these men, catholic in their sympathies, scholarly in spirit and method, prove the purveyors and distributors through whom new ideas are harmonized and made current. They preserve balance and make connections."[1] Between 1950 and 1965 biomedical research activities of the schools of medical education continued to increase and the federal government assumed a progressively larger responsibility for the support of biomedical research activities of medical schools. In 1961, 73% of the medical school expenditures for sponsored biomedical research derived from federal grants. By 1965, medical research conducted in schools of medical education cost $375 million and constituted 42% of the entire expenditures of the academic medical center.[5]

By early 1960, public outcry against the disappearance of general practitioners, the increasing specialization of physicians, the demand for increased accessibility to health care, caused some medical educators to begin to rethink the university affiliated, research oriented medical school and suggest the development of a new type of medical school, the community-based medical school.

It is appropriate to review German medical education between 1910 and 1925 if we are to place the evolution of the new "community based medical school" in perspective. As noted earlier, by 1910 the university based medical schools in Germany were superior to those in any other country. However, as Germany began to prepare for the

first world war, distinct murmurs began to be heard that biomedical research was not only becoming more and more costly, but the medical research laboratories were less important than the development of a new warship. Money became short; apparatus, supplies, animals and books became unobtainable. The empire attached its own political fortunes to the brains of the universities and the universities became crowded with students. Emphasis in medical education was on training students to practice medicine and to minimize the time devoted to research on the part of the faculty. Research was removed from the universities and scientific institutes isolated from the education of medical students were developed. Between 1910 and 1925 German medical education deteriorated to the point where the education provided to medical students was comparable or even less satisfactory than that accomplished in other countries of the world.[2]

It is interesting to observe that this deterioration in German medical education coincided with the shift from the scientific based medical school to a clinically oriented school designed to turn out large numbers of physicians. This historical precedent is comparable to that in the United States at the turn of the century when the justification for the existence of low quality, high volume, proprietary medical schools was the acute need for more doctors. In commenting on the public cry for more doctors, Flexner indicated "The problem is, of course, practical and not academic. Pending the homogenous filling-up of the whole country, inequalities must be tolerated.

Man has not been inaptly differentiated as the animal with 'the desire to take medicine'. When sick he craves the comfort of a doctor, any doctor rather than none at all, and this he will not be denied. The question is, then, not merely to define the idea of training of a physician; it is just as much, at this particular junction, to strike the solution, that economic and social factors being what they are, will distribute as widely as possible the best type of physicians so distributable." ... "It would appear, then, that over-production on a low basis does not effectively overcome the social or economic obstacles to spontaneous dispersion."[1] In commenting on the shortage of physicians in some localities, Flexner indicated "It would appear, then, that perhaps the salvation of these districts might, under existing circumstances, be better worked out by a different model. A large area would support one good man, whereas separate fragments are unable to support even one poor man. A physician's range, actual and virtual, increases with his competency. A well-qualified doctor may perhaps at a central point set up a small hospital, where the seriously ill of the entire district may receive good care. The region is thus better served by one well-trained man than it could possibly be even if over-production on a low basis ultimately succeeded in forcing an incompetent into every hamlet of 5 and 20 souls."[1]

During the mid-1960s, the increasing American public demand for more readily accessible medical care produced a public out-cry against the scarcity of doctors, the increasing specialization of physicians, the high cost of medical care, the high cost of medical education and

the research oriented medical school. Some medical educators responded to this pressure by developing the concept of a community-based medical school. In these programs, the student receives his basic science education at an academic medical center, or, in other models, at a university science center unaffiliated with a medical school. Physical diagnosis, clinical clerkship and electives are developed at affiliated community hospitals staffed by a small core of full-time faculty. The major portion of clinical teaching is provided by volunteer or part-time practicing physicians. The full-time faculty at these community hospitals are full-time teachers who spend a small portion of their time in the delivery of health care and a negligible portion devoted to scholarly activities, such as biomedical research.

Development of the community-based, 'modern' medical school was not the only response of medical education to the public demand for greater accessibility to high-quality medical care. Many institutions began to increase their involvement in programs directed toward the delivery of health care. As noted earlier, in 1965 medical research conducted in schools of medicine cost $375 million and constituted 42% of the entire expenditures of the academic medical center. By 1971, expenditures for biomedical research were $481 million but this constituted only 28% of the expenditures of the entire academic medical center, which rose from $882 million in 1965-66 to $1.713 billion in 1970-71.[5] Biomedical research had become a

relatively less dominant part of the activities of the academic medical center. Indeed, certain medical educators and state legislators suggested that the United States duplicate the German experience, where biomedical research would be conducted in research institutes and medical schools would devote their entire effort to the education of physicians who would be trained to deliver health care. Some have suggested that physician faculty should put down their test tubes, get out of the ivory towers and participate in the delivery of health care in order to improve our nation's health. This commentary should not be interpreted as a cynical response to the demand of the American public for increased accessibility to health care and a clear cut need to reform our system of health care delivery. Nevertheless, it is clear that the concept of a medical school devoted solely to the instruction of candidates for the M.D. degree would create a non-viable institution. Medical schools must also provide opportunity for advanced study in the various fields of medicine, must develop the specialists and teachers of the next generation and must investigate the problems of health and disease. Thus, scholarly pursuits such as biomedical research are a critically important part of the activities of medical school faculty. Our own history and the German experience tell us that the development of medical schools which place insufficient emphasis on the need for scholarly activity by faculty will ultimately result in a system of medical education which produces poorly trained physicians.

Although participation by the faculty in scholarly pursuits such as biomedical research should be on a voluntary basis, it is important that the medical school encourage among its faculty a zest for the discovery of new knowledge, an eagerness to communicate this knowledge and provide an atmosphere conducive to the development of scholarship. The institutional commitment of the modern American medical school to the academic growth and development of its faculty should include a guarantee that the faculty will have sufficient time to participate in scholarly pursuits as part of its regular academic program. Biomedical research programs are expensive and the faculty should be encouraged to solicit research support through gifts, grants and contracts to provide support for their research programs. Although it is imperative that the investigator's freedom in research, including the direction of the program and communication of results, be preserved, institutional biomedical research policy should ensure that these activities conform to the purposes of the institution and provide an appropriate balance between research, instruction and patient care.

SUMMARY

Modern medicine is concerned with the application of a changing body of knowledge and technology to the problems of health and disease. It is essential that the student of medicine have a direct encounter with the scientific processes involved in 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 and application. To develop these characteristics in a physician, medical education must encompass the opportunity for the medical student to engage with exemplary faculty in the use of the scientific method for investigative processes directed toward the discovery of new knowledge. This can only be accomplished by a faculty that is involved in adequate measure with the development of knowledge at the frontiers of the health sciences through their own research activities.

REFERENCES

1. Flexner, A. 1910. Medical Education in the United States and Canada: A report to the Carnegie Foundation for the Advancement of Teaching. Bulletin No. 4. New York.

2. Flexner, A. 1925. Medical Education: A Comparative Study, New York: MacMillan

3.

4. Deitrick, J.E., and Berson, R.C. 1953. Medical Schools in the United States at Mid-Century. New York:McGraw-Hill.

5. American Medical Association Council on Medical Education. 1972. Medical Education in the United States, 1971-72, JAMA, 222:990.

The five basic programs to which this effort is dedicated includes: the development of a system for the appraisal of educational materials in non-traditional formats (audiovisual, computer-based instruction, simulations, etc.); the development and implementation of a clearinghouse system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by students and faculties; and other areas of mutual concern regarding the use of educational technology in health science education.

One of the initial tasks undertaken was that of surveying the medical and dental school faculties in an attempt to ascertain what these individuals have identified as effective educational materials (either self-instructional or lecture support in format), whether they could be made available for peer review and whether they might be available for use by other institutions.

The responses to these queries have helped to identify the existence of 5,944 items. Added to the survey conducted by the American Association of Dental Schools (AADS) (1,495 items) and those previously identified by professional groups and the National Medical Audiovisual Center (NMAC) (13,375 items), it was possible to provide a list of 20,814 items that could be subjected to national peer review panels.

Up to the present time, nine interdisciplinary panels have convened to review and appraise educational materials (predominately lecture-support audiovisuals) in anatomy, ophthalmology, neurosciences, cardiovascular system, oral pathology, periodontics, operative/restorative dentistry, behavioral sciences and the musculoskeletal system. The criteria used, the results obtained and a listing of the panelists participating in these reviews will be contained in a progress report to be distributed during July, 1974.

A brief summary indicates that during these nine reviews, 1,543 items have been appraised of which 805 have been deemed acceptable for inclusion in the AVLINE data base. A rating of "excellent" was achieved by 150 of the accepted items.

The items recommended by the panelists will be included in the National Library of Medicine's data base designated as "AVLINE" which will be available in a format similar to the MEDLINE system. It is anticipated that this data base will be available for use in early 1975. The process of adding to and up-dating the AVLINE data base will be an ongoing process as we continue to seek to identify, evaluate and make available for use those educational materials that have been proven to be effective in medical and dental education.

The continued cooperation of the AAMC constituency is essential for the growth, validation and utility of this educational resource.

4

Supplementary Item

DRAFT QUESTIONNAIRE - INJURIES SUSTAINED DURING RESEARCH

TO: Deans

As a result of the increasing national concern about the ethical aspects of biomedical research, legislators are beginning to raise questions about the number of subjects of biomedical research who have been injured or harmed as a consequence of participation in biomedical research programs. In order to develop information to serve as a data base from which inquiries can be answered, the following brief questionnaire has been developed. We shall treat your response in a confidential manner and, following collation of the data, will not identify responses provided from an individual school.

During the past five years:

1. What is the approximate number of all research projects involving human subjects conducted over the past five years?

   _____

2. What is the approximate average number of persons participating as subjects of biomedical research projects at your institution each year?

   _____

3. What is the approximate age distribution of your research subjects?

   (Check in order as primary, secondary, tertiary or not included)

   Children _____

   Adults _____

   Older Adults _____

4. How many patients/subjects have been seriously injured as a direct result of participation in research projects conducted by your institution?

_____

5. How many of these injuries have resulted in claims against your institution or its staff?

_____

6. How many of these claims have been settled at a cost to your institution or its insurance carrier?

_____

What is your best estimate of these costs?

_____

7. How many possible claims have been "deferred" by institutional delivery of services, care or other considerations?

_____

8. What insurance option does your institution utilize?

Self-insured _____

Insured through Insurance Carrier _____

Insured through State Government _____

9. Does your current insurance program cover the innocent victim of biomedical research?

_____

What is your maximum liability under this program?

_____

10. If your current insurance program does not include coverage for the innocent victims of research, could you briefly indicate the reason?

_____

_____

11. School _____

6/11/74

Information Item

[CONFERENCE COMMITTEE PRINT]

JUNE 10, 1974

93D CONGRESS 2d Session } HOUSE OF REPRESENTATIVES { REPORT No. ------

NATIONAL RESEARCH TRAINING AND PROTECTION OF HUMAN RESEARCH SUBJECTS ACT OF 1974

----------Ordered to be printed

Mr. ----------, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 7724]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 7724) to amend the Public Health Service Act to establish a national program of biomedical research fellowships, traineeships, and training to assure the continued excellence of biomedical research in the United States, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment to the text of the bill insert the following:

Section 1. This Act may be cited as the "National Research Training and Protection of Human Research Subjects Act of 1974".

TITLE I—BIOMEDICAL AND BEHAVIORAL RESEARCH TRAINING

SHORT TITLE

SEC. 101. This title may be cited as the "National Research Service Award Act of 1974".

FINDINGS AND DECLARATION OF PURPOSE

SEC. 102. (a) Congress finds and declares that—

(1) the success and continued viability of the Federal biomedical and behavioral research effort depends on the availability of

excellent scientists and a network of institutions of excellence capable of producing superior research personnel;

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

(3) graduate research assistance programs should be the key elements in the training programs of the institutes of the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration.

(b) It is the purpose of this title to increase the capability of the institutes of the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration to carry out their responsibility of maintaining a superior national program of research into the physical and mental diseases and impairments of man.

BIOMEDICAL AND BEHAVIORAL RESEARCH TRAINING

SEC. 103. Part H of title IV of the Public Health Service Act is amended by adding after section 461 the following new sections:

"NATIONAL RESEARCH SERVICE AWARDS

"SEC. 462. (a)(1) The Secretary shall provide National Research Service Awards for—

"(A) biomedical and behavioral research at the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration in matters relating to the cause, diagnosis, prevention, and treatment of the disease (or diseases) or other health problems to which the activities of the Institutes and Administration are directed,

"(B) training at the Institutes and Administration of individuals to undertake such research,

"(C) biomedical and behavioral research at non-Federal public institutions and at nonprofit private institutions, and

"(D) pre- and postdoctoral training at such public and private institutions of individuals to undertake such research.

A reference in this subsection to the National Institutes of Health or the Alcohol, Drug Abuse, and Mental Health Administration shall be considered to include the institutes, divisions, and bureaus included in the Institutes or under the Administration, as the case may be.

"(2) National Research Service Awards may not be used to support residencies.

"(3) Effective July 1, 1975, National Research Service Awards may be made for research or research training in only those subject areas for which, as determined under section 463, there is a need for personnel.

"(b)(1) No National Research Service Award may be made by the Secretary to any individual unless—

"(A) the individual has submitted to the Secretary an application therefor and the Secretary has approved the application;

"(B) the individual provides, in such form and manner as the Secretary shall by regulation prescribe, assurances satisfactory to the Secretary that the individual will meet the service requirement of subsection (c)(1); and

"(C) *in the case of a National Research Service Award for a purpose described in subsection (a)(1)(C) or (a)(1)(D), the individual has been sponsored (in such manner as the Secretary may by regulation require) by the institution at which the research or training under the Award will be conducted.*

An application for an Award shall be in such form, submitted in such manner, and contain such information, as the Secretary may by regulation prescribe.

"(2) *The award of National Research Service Awards by the Secretary under subsection (a) shall be subject to review and approval by the appropriate advisory councils to the entities of the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration (A) whose activities relate to the research or training under the Awards, or (B) at which such research or training will be conducted.*

"(3) *The period of any National Research Service Award made to any individual under subsection (a) may not exceed three years in the aggregate unless the Secretary for good cause shown waives the application of the three-year limit to such individual.*

"(4) *National Research Service Awards shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the recipients of the Awards as the Secretary may deem necessary. A National Research Service Award made to an individual for research or research training at a non-Federal public or nonprofit private institution shall also provide for payments to be made to the institution for the cost of support services (including the cost of faculty salaries, supplies, equipment, general research support, and related items) provided such individual by such institution. The amount of any such payments to any institution shall be determined by the Secretary and shall bear a direct relationship to the reasonable costs of the institution for establishing and maintaining the quality of its biomedical and behavioral research and training programs.*

"(c)(1)(A) *Each individual who receives a National Research Service Award shall, in accordance with paragraph (3), engage in—*

"(i) *health research or teaching,*

"(ii) *if authorized under subparagraph (B), serve as a member of the National Health Service Corps or serve in his specialty, or*

"(iii) *if authorized under subparagraph (C), serve in a health related activity approved under that subparagraph,*

for a period computed in accordance with paragraph (2).

"(B) *Any individual who received a National Research Service Award and who is a physician, dentist, nurse, or other individual trained to provide health care directly to individual patients may, upon application to the Secretary, be authorized by the Secretary to—*

"(i) *serve as a member of the National Health Service Corps,*

"(ii) *serve in his specialty in private practice in a geographic area designated by the Secretary as requiring that specialty, or*

"(iii) *serve in his specialty as a member of a nonprofit prepaid group practice which may be reimbursed under title XVIII of the Social Security Act,*

in lieu of engaging in health research or teaching if the Secretary determines that there are no suitable health research or teaching positions available to such individual.

"(C) Where appropriate the Secretary may, upon application, authorize a recipient of a National Research Service Award, who is not trained to provide health care directly to individual patients, to engage in a health-related activity in lieu of engaging in health research or teaching if the Secretary determines that there are no suitable health research or teaching positions available to such individual.

"(2) For each year for which an individual receives a National Research Service Award he shall—

"(A) for twelve months engage in health research or teaching or, if so authorized, serve as a member of the National Health Service Corps, or

"(B) if authorized under paragraph (1)(B) or (1)(C), for twenty months serve in his specialty or engage in a health-related activity.

"(3) The requirement of paragraph (1) shall be complied with by any individual to whom it applies within such reasonable period of time, after the completion of such individual's Award, as the Secretary shall by regulation prescribe. The Secretary shall (A) by regulation prescribe (i) the type of research and teaching which an individual may engage in to comply with such requirement, and (ii) such other requirements respecting such research and teaching and alternative service authorized under paragraphs (1)(B) and (1)(C) as he deems necessary; and (B) to the extent feasible, provide that the members of the National Health Service Corps who are serving in the Corps to meet the requirement of paragraph (1) shall be assigned to patient care and to positions which utilize the clinical training and experience of the members.

"(4)(A) If any individual to whom the requirement of paragraph (1) is applicable fails, within the period prescribed by paragraph (3), to comply with such requirement, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula—

$$A = \phi\left(\frac{t - 1/2s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover; 'ϕ' is the sum of the total amount paid under one or more National Research Service Awards to such individual and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at a rate fixed by the Secretary of the Treasury after taking into consideration private consumer rates of interest prevailing at the time each Award to such individual was made; 't' is the total number of months in such individual's service obligation; and 's' is the number of months of such obligation served by him in accordance with paragraphs (1) and (2) of this subsection.

"(B) Any amount which the United States is entitled to recover under subparagraph (A) shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount,

be paid to the United States. Until any amount due the United States under subparagraph (A) on account of any National Research Service Award is paid, there shall accrue to the United States interest on such amount at the same rate as that fixed by the Secretary of the Treasury under subparagraph (A) to determine the amount due the United States.

"(4)(A) Any obligation of any individual under paragraph (3) shall be canceled upon the death of such individual.

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

"(d) There are authorized to be appropriated to make payments under National Research Service Awards $207,947,000 for the fiscal year ending June 30, 1975.

"STUDIES RESPECTING BIOMEDICAL AND BEHAVIORAL RESEARCH PERSONNEL

"SEC. 463. (a) The Secretary shall, in accordance with subsection (b), arrange for the conduct of a continuing study to—

"(1) establish (A) the Nation's overall need for biomedical and behavioral research personnel, (B) the subject areas in which such personnel are needed and the number of such personnel needed in each such area, and (C) the kinds and extent of training which should be provided such personnel;

"(2) assess (A) current training programs available for the training of biomedical and behavioral research personnel which are conducted under this Act at or through institutes under the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration, and (B) other current training programs available for the training of such personnel;

"(3) identify the kinds of research positions available to and held by individuals completing such programs;

"(4) determine, to the extent feasible, whether the programs referred to in clause (B) of paragraph (2) would be adequate to meet the needs established under paragraph (1) if the programs referred to in clause (A) of paragraph (2) were terminated; and

"(5) determine what modifications in the programs referred to in paragraph (2) are required to meet the needs established under paragraph (1).

"(b)(1) The Secretary shall request the National Academy of Sciences to conduct the study required by subsection (a) under an arrangement under which the actual expenses incurred by such Academy in conducting such study will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the Secretary shall enter into such an arrangement with such Academy for the conduct of such study.

"(2) If the National Academy of Sciences is unwilling to conduct such study under such an arrangement, then the Secretary shall enter into a similar arrangement with other appropriate nonprofit private

groups or associations under which such groups or associations will conduct such study and prepare and submit the reports thereon as provided in subsection (c).

"(c) A report on the results of such study shall be submitted by the Secretary to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate not later than March 31 of each year."

CONFORMING AMENDMENTS

SEC. 104. (a)(1) Section 301 of the Public Health Service Act is amended (A) by striking out paragraph (c); (B) by striking out in paragraph (d) "or research training" each place it occurs, "and research training programs", and "and research training program"; and (C) by redesignating paragraphs (d), (e), (f), (g), (h), and (i) as paragraphs (c), (d), (e), (f), (g), and (h), respectively.

(2)(A) Section 303(a)(1) of such Act is amended to read as follows:

"(1) to provide clinical training and instruction and to establish and maintain clinical traineeships (with such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary);".

(B) Section 303(b) of such Act is amended by inserting before the first sentence the following: "The Secretary may provide for training, instruction, and traineeships under subsection (a)(1) through grants to public and other nonprofit institutions.".

(3) Section 402(a) of such Act is amended (A) by striking out "training and instruction" in paragraph (3) and inserting in lieu thereof "clinical training and instruction", and (B) by striking out paragraph (4) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(4) Section 407(b)(7) of such Act is amended (A) by striking out "and basic research and treatment", and (B) by striking out "where appropriate".

(5) Section 408(b)(3) of such Act is amended by inserting "clinical" before "training" each place it occurs.

(6) Section 412(7) of such Act is amended by striking out "(1) establish and maintain" and all that follows down through and including "maintain traineeships" and inserting in lieu thereof ", provide clinical training and instruction and establish and maintain clinical traineeships".

(7) Section 413(a)(7) is amended by inserting "clinical" before "programs".

(8) Section 415(b) is amended by inserting before the period at the end of the last sentence thereof the following: "; and the term 'training' does not include research training for which fellowship support may be provided under section 462".

(9) Section 422 of such Act is amended (A) by striking out paragraph (c) and by redesignating paragraphs (d), (e), and (f) as paragraphs (c), (d), and (e), respectively, and (B) by striking out

"training and instruction and establish and maintain traineeships" in paragraph (c) (as so redesignated) and inserting in lieu thereof "clinical training and instruction and establish and maintain clinical traineeships".

(10) Section 434(c)(2) of such Act is amended by inserting "(other than research training for which National Research Service Awards may be made under section 462)" after "training" the first time it occurs.

(11) Sections 433(a), 444, and 453 of such Act are each amended by striking out the second sentence thereof.

(12) The heading for part H of title IV of such Act is amended by striking out "ADMINISTRATIVE" and inserting in lieu thereof "GENERAL."

(b) The amendments made by subsection (a) shall not apply with respect to commitments made before the date of the enactment of this Act by the Secretary of Health, Education, and Welfare for research training under the provisions of the Public Health Service Act amended or repealed by subsection (a).

SEX DISCRIMINATION

SEC. 105. Section 799A of the Public Health Service Act is amended by adding at the end thereof the following: "In the case of a school of medicine which—

"(1) on the date of the enactment of this sentence is in the process of changing its status as an institution which admits only female students to that of an institution which admits students without regard to their sex, and

"(2) change is being carried out in accordance with a plan approved by the Secretary,

the provisions of the preceding sentences of this section shall apply only with respect to a grant, contract, loan guarantee, or interest subsidy to, or for the benefit of such a school for a fiscal year beginning after June 30, 1979."

FINANCIAL DISTRESS GRANTS

SEC. 106. Section 773(a) of the Public Health Service Act is amended by striking out "$10,000,000" and inserting in lieu thereof "$15,000,000".

TITLE II—PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH

PART A—NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORIAL RESEARCH

ESTABLISHMENT OF COMMISSION

SEC. 201. (a) There is established a Commission to be known as the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (hereinafter in this title referred to as the "Commission").

(b)(1) The Commission shall be composed of eleven members appointed by the Secretary of Health, Education, and Welfare (hereinafter in this title referred to as the "Secretary"). The Secretary shall select members of the Commission from individuals distinguished in the fields of medicine, law, ethics, theology, the biological, physical, behavioral and social sciences, philosophy, humanities, health administration, government, and public affairs; but five (and not more than five) of the members of the Commission shall be individuals who are or who have been engaged in biomedical or behavorial research involving human subjects. In appointing members of the Commission, the Secretary shall give consideration to recommendations from the National Academy of Sciences and other appropriate entities. Members of the Commission shall be appointed for the life of the Commission. A member of the Commission shall not be eligible for appointment to the National Advisory Council for the Protection of Subjects of Biomedical and Behavioral Research.

(2)(A) Except as provided in subparagraph (B), members of the Commission shall each be entitled to receive the daily equivalent of the annual rate of the basic pay in effect for grade GS-18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of the duties of the Commission.

(B) Members of the Commission who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Commission.

(C) While away from their homes or regular places of business in the performance of duties of the Commission, members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5 of the United States Code.

(c) The chairman of the Commission shall be selected by the members of the Commission from among their number.

(d)(1) The Commission may appoint and fix the pay of such staff personnel as it deems desirable. Such personnel shall be appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

(2) The Commission may procure temporary and intermittent services to the same extent as is authorized by section 3109(b) of title 5 of the United States Code, but at rates for individuals not to exceed the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule.

COMMISSION DUTIES

SEC. 202. (a) The Commission shall carry out the following:

(1)(A) The Commission shall (i) conduct a comprehensive investigation and study to identify the basic ethical principles which should underlie the conduct of biomedical and behavioral research involving human subjects, (ii) develop guidelines which should be followed in

such research to assure that it is conducted in accordance with such principles, and (iii) make recommendations to the Secretary (I) for such administrative action as may be appropriate to apply such guidelines to biomedical and behavioral research conducted or supported under programs administered by the Secretary, and (II) concerning any other matter pertaining to the protection of human subjects of biomedical and behavioral research.

(B) In carrying out subparagraph (A), the Commission shall consider at least the following:

(i) The boundaries between biomedical or behavioral research involving human subjects and the accepted and routine practice of medicine.

(ii) The role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects.

(iii) Appropriate guidelines for the selection of human subjects for participation in biomedical and behavioral research.

(iv) The nature and definition of informed consent in various research settings.

(v) Mechanisms for evaluating and monitoring the performance of Institutional Review Boards established in accordance with section 464 of the Public Health Service Act and appropriate enforcement mechanisms for carrying out their decisions.

(C) The Commission shall consider the appropriateness of applying the principles and guidelines identified and developed under subparagraph (A) to the delivery of health services to patients under programs conducted or supported by the Secretary.

(2) The Commission shall identify the requirements for informed consent to participation in biomedical and behavioral research by children, prisoners, and the institutionalized mentally infirm. The Commission shall investigate and study biomedical and behavioral research conducted or supported under programs administered by the Secretary and involving children, prisoners, and the institutionalized mentally infirm to determine the nature of the consent obtained from such persons or their legal representatives before such persons were involved in such research; the adequacy of the information given them respecting the nature and purpose of the research, procedures to be used, risks and discomforts, anticipated benefits from the research, and other matters necessary for informed consent; and the competence and the freedom of the persons to make a choice for or against involvement in such research. On the basis of such investigation and study the Commission shall make such recommendations to the Secretary as it determines appropriate to assure that biomedical and behavioral research conducted or supported under programs administered by him meets the requirements respecting informed consent identified by the Commission. For purposes of this paragraph, the term "children" means individuals who have not attained the legal age of consent to participate in research as determined under the applicable law of the jurisdiction in which the research is to be conducted; the term "prisoner" means individuals involuntarily confined in penal institutions; and the term "institutionalized mentally infirm" includes individuals who are

mentally ill, mentally retarded, emotionally disturbed, psychotic, or senile, or who have other impairments of a similar nature and who reside as patients in an institution.

(3) The Commission shall conduct an investigation and study to determine the need for a mechanism to assure that human subjects in biomedical and behavioral research not subject to regulation by the Secretary are protected. If the Commission determines that such a mechanism is needed, it shall develop and recommend to the Congress such a mechanism. The Commission may contract for the design of such a mechanism to be included in such recommendations.

(b) The Commission shall conduct an investigation and study of the nature and extent of research involving living fetuses, the purposes for which such research has been undertaken, and alternative means for achieving such purposes. The Commission shall, not later than four months after the month in which the Commission is established, recommend to the Secretary policies defining the circumstances (if any) under which such research may be conducted.

(c) The Commission shall conduct an investigation and study of the use of psychosurgery in the United States during the five-year period ending December 31, 1972. The Commission shall determine the appropriateness of its use, evaluate the need for it, and recommend to the Secretary policies defining the circumstances (if any) under which its use may be appropriate. For purposes of this paragraph, the term "psychosurgery" means brain surgery on (1) normal brain tissue of an individual, who does not suffer from any physical disease, for the purpose of changing or controlling the behavior or emotions of such individual, or (2) diseased brain tissue of an individual, if the sole object of the performance of such surgery is to control, change, or affect any behavioral or emotional disturbance of such individual. Such term does not include brain surgery designed to cure or ameliorate the effects of epilepsy and electric shock treatments.

(d) The Commission shall make recommendations to the Congress respecting the functions and authority of the National Advisory Council for the Protection of Subjects of Biomedical and Behavioral Research to be estabilshed under section 217(f) of the Public Health Service Act.

SPECIAL STUDY

SEC. 203. The Commission shall undertake a comprehensive study of the ethical, social, and legal implications of advances in biomedical and behavioral research and technology. Such study shall include—

(1) an analysis and evaluation of scientific and technological advances in past, present, and projected biomedical and behavioral research and services;

(2) an analysis and evaluation of the implications of such advances, both for individuals and for society;

(3) an analysis and evaluation of laws and moral and ethical principles governing the use of technology in medical practice;

(4) an analysis and evaluation of public understanding of and attitudes toward such implications and laws and principles; and

(5) an analysis and evaluation of implications for public policy of such findings as are made by the Commission with respect to advances in biomedical and behavioral research and technology and public attitudes toward such advances.

ADMINISTRATIVE PROVISIONS

SEC. 204. (a) The Commission may for the purpose of carrying out its duties under sections 202 and 203 hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission deems advisable.

(b) The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out its duties. Upon the request of the chairman of the Commission, the head of such department or agency shall furnish such information to the Commission.

(c) The Commission shall not disclose any information reported to or otherwise obtained by it in carrying out its duties which (1) identifies any individual who has been the subject of an activity studied and investigated by the Commission, or (2) which concerns any information which contains or relates to a trade secret or other matter referred to in section 1905 of title 18 of the United States Code.

(d) Except as provided in subsection (b) of section 202, the Commission shall complete its duties under sections 202 and 203 not later than twenty-four months after the month in which the Commission is established. The Commission shall make periodic reports to the President, the Congress, and the Secretary respecting its activities under sections 202 and 203 and shall, not later than ninety days after the expiration of such twenty-four months, make a final report to the President, the Congress, and the Secretary respecting such activities and including its recommendations for administrative action and legislation.

(e) The Commission shall cease to exist thirty days following the submission of its final report pursuant to subsection (d).

DUTIES OF THE SECRETARY

SEC. 205. Within 60 days of the receipt of any recommendation made by the Commission under section 202, the Secretary shall publish it in the Federal Register and provide opportunity for interested persons to submit written data, views, and arguments with respect to such recommendation. The Secretary shall consider the Commission's recommendation and relevant matter submitted with respect to it and, within 180 days of the date of its publication in the Federal Register, the Secretary shall (1) determine whether the administrative action proposed by such recommendation is appropriate to assure the protection of human subjects of biomedical and behavioral research conducted or supported under programs administered by him, and (2) if he determines that such action is not so appropriate, publish in the Federal Register such determination together with an adequate statement of the reasons for his determination. If the Secretary determines that administrative action recommended by the Commission

should be undertaken by him, he shall undertake such action as expeditiously as is feasible.

Part B—Miscellaneous

National Advisory Council for the Protection of Subjects of Biomedical and Behavioral Research

Sec. 211. (a) Section 217 of the Public Health Service Act is amended by adding at the end the following new subsection:

"(f)(1) There shall be established a National Advisory Council for the Protection of Subjects of Biomedical and Behavioral Research (hereinafter in this subsection referred to as the 'Council') which shall consist of the Secretary who shall be Chairman and not less than seven nor more than fifteen other members who shall be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall select members of the Council from individuals distinguished in the fields of medicine, law, ethics, theology, the biological, physical, behavioral and social sciences, philosophy, humanities, health administration, government, and public affairs; but three (and not more than three) of the members of the Council shall be individuals who are or who have been engaged in biomedical or behavioral research involving human subjects. The appointed members of the Council shall have terms of office of four years, except that for the purpose of staggering the expiration of the terms of office of the Council members the Secretary shall, at the time of appointment, designate a term of office of less than four years for members first appointed to the Council.

"(2) The Council shall—

"(A) advise, consult with, and make recommendations to the Secretary concerning all matters pertaining to the protection of human subjects of biomedical and behavioral research;

"(B) review policies, regulations, and other requirements of the Secretary governing such research to determine the extent to which such policies, regulations, and requirements require and are effective in requiring observance in such research of the basic principles which should underlie the conduct of such research and, to the extent such policies, regulations, or requirements do not require or are not effective in requiring observance of such principles, make recommendations to the Secretary respecting appropriate revision of such policies, regulations, or requirements; and

"(C) review periodically changes in the scope, purpose, and types of biomedical and behavioral research being conducted and the impact such changes have on the policies, regulations, and other requirements of the Secretary for the protection of human subjects of such research.

"(3) The Council may disseminate to the public such information, recommendations, and other matters relating to its functions as it deems appropriate.

"(4) Section 14 of the Federal Advisory Committee Act shall not apply with respect to the Council."

(b) The amendment made by subsection (a) shall take effect July 1, 1976.

Institutional Review Boards; Ethics Guidance Program

Sec. 212. (a) Part H of title IV of the Public Health Service Act, as amended by section 103 of this Act, is amended by adding at the end the following new section:

"INSTITUTIONAL REVIEW BOARDS; ETHICS GUIDANCE PROGRAM

"SEC. 464. (a) The Secretary shall by regulation require that each entity which applies for a grant or contract under this Act for any project or program which involves the conduct of biomedical or behavioral research involving human subjects submit in or with its application for such grant or contract assurances satisfactory to the Secretary that it has established (in accordance with regulations which the Secretary shall prescribe) a board (to be known as an 'Institutional Review Board') to review biomedical and behavioral research involving human subjects conducted at or sponsored by such entity in order to protect the rights of the human subjects of such research.

"(b) The Secretary shall establish a program within the Department under which requests for clarification and guidance with respect to ethical issues raised in connection with biomedical or behavioral research involving human subjects are responded to promptly and appropriately."

(b) The Secretary of Health, Education, and Welfare shall within 240 days of the date of the enactment of this Act promulgate such regulations as may be required to carry out section 464(a) of the Public Health Service Act. Such regulations shall apply with respect to applications for grants and contracts under such Act submitted after promulgation of such regulations.

LIMITATION ON RESEARCH

SEC. 213. Until the Commission has made its recommendations to the Secretary pursuant to section 202(b), the Secretary may not conduct or support research in the United States or abroad on a living human fetus, before or after the induced abortion of such fetus, unless such research is done for the purpose of assuring the survival of such fetus.

INDIVIDUAL RIGHTS

SEC. 214. (a) Subsection (c) of section 401 of the Health Programs Extension Act of 1973 is amended (1) by inserting "(1)" after "(c)", (2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and (3) by adding at the end the following new paragraph:

"(2) No entity which receives after the date of enactment of this paragraph a grant or contract for biomedical or behavioral research under any program administered by the Secretary of Health, Education, and Welfare may—

"(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or

"(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel,

because he performed or assisted in the performance of any lawful health service or research activity, because he refused to perform or assist in the performance of any such service or activity on the grounds that his performance or assistance in the performance or such service or activity would be contrary to his religious beliefs or moral convic-

tions, or because of his religious beliefs or moral convictions respecting any such service or activity."

(b) Section 401 of such Act is amended by adding at the end the following new subsection:

"(d) No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health, Education, and Welfare if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."

SPECIAL PROJECT GRANTS AND CONTRACTS

SEC. 215. Section 772(a)(7) of the Public Health Service Act is amended by inserting immediately before the semicolon at the end thereof the following: ", or (C) providing increased emphasis on the ethical, social, legal, and moral implications of advances in biomedical research and technology with respect to the effects of such advances on individuals and society".

And the Senate agree to the same.

That the House recede from its disagreement to the amendment of the Senate to the title of the bill and agree to the same.

O

ISSUES

POLICIES

PROGRAMS

OF THE

ASSOCIATION OF

AMERICAN MEDICAL COLLEGES

AN AAMC WORKING PAPER

April 1974

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Founded 1876

"The purpose of the Association is the advancement of medical education. In pursuing this purpose, it shall strengthen, expand, and cooperate with all educational programs that are important to the nation's health, with particular concern for the entire span of education and training for the medical profession and health sciences. The Association will foster studies and research, provide means of communication and forums, and perform services necessary to program and policy decisions that the above broad objectives require."

One Dupont Circle, N.W.
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FOREWORD

This publication has been developed by the staff of the Association of American Medical Colleges in response to a recommendation of its Council of Deans and Executive Council. The document presents:

1. the major issues which the Association faces as the national representative of U.S. medical schools and teaching hospitals;

2. the Association's current policy or steps to develop policy on each particular issue; and

3. AAMC activities undertaken in an effort to achieve the goals related to those policies.

In response to a proposal developed by the Council of Deans at their 1973 spring meeting in San Antonio, the COD Administrative Board recommended that the staff prepare "a new document setting forth a summary of where the AAMC stands on major issues facing the Nation in the areas of medical education, biomedical research, delivery of health services, and the financing of these activities...." The Board also specified that the document clearly define AAMC efforts toward policy formulation and progress toward identified goals. At its June 22, 1973 meeting, the Executive Council adopted the recommendation of the COD Administrative Board.

This working paper will be presented to the Council of Deans at their 1974 spring meeting, and to all AAMC Administrative Boards and the Executive Council in June. If the document is approved at that time, it will be published for distribution to the constituent members of the Association. Additional distribution, if any, of the final publication will be determined by the Executive Council.

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I. QUALITY OF MEDICAL EDUCATION

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE:

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Institutional Development

AAMC COMMITTEE:

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

In March 1974 the Executive Council approved the FMG Task Force report which recommends ". . .that a generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until another such examination may become available, Parts I and II of the National Board Examination should be employed for this purpose."

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Department of Institutional Development

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Faculty Development of the Department of Academic Affairs

AAMC COMMITTEE:

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

A workshop was held February 1969 entitled "Potential Educational Services From A National Biomedical Communications Network." Subsequently, the AAMC Biomedical Communications Network Steering Committee was established in 1969. A series of recommendations were presented to both the NLM and the academic community defining the roles and responsibilities of both the academic community and the Federal Government in enhancing the uses of educational technology in medical education. Reports were published as supplements to the Journal of Medical Education: Educational Technology for Medicine: Roles for the Lister Hill Center (J. Med. Educ., 46: July (Part 2) 1971) and Educational Technology for Medicine: Academic Institutions and Program Management (J. Med. Educ., 48: 203-226, February 1973).

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Educational Resources

AAMC COMMITTEE:

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

II. UNDERGRADUATE MEDICAL EDUCATION

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE: Task Force on Primary Care

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of International Medical Education

AAMC COMMITTEE:

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

III. GRADUATE MEDICAL EDUCATION

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

By action of the Assembly in 1971, a position statement (published in AAMC Bulletin, Nov. 15, 1971) recommends that the academic medical centers assume responsibility for graduate medical education in a fashion analogous to that for which they have responsibility for undergraduate medical education. This implies that the faculty of the institutions as a whole should assume responsibility for planning and evaluating the graduate programs of instruction and should set the standards for student selection, progress and certification for readiness to be examined by specialty boards. The program further recommends that freestanding hospitals desiring to continue or develop graduate medical education programs should seek affiliation with university academic centers or should develop sufficient resources to permit their being accredited as freestanding graduate medical schools. This position statement was evolved subsequent to a conference of the Council of Academic Societies in 1968; the proceedings were published as a special issue of the Journal of Medical Education (J. Med. Educ., 44: September (Special Issue) 1969). A committee chaired by Thomas Kinnedy published the IMPLICATIONS document (J. Med. Educ., 44: 77-84, February 1972).

PROGRESS TOWARD ACCOMPLISHMENT:

The Graduate Medical Education Committee, chaired by William G. Anlyan published a supplement to the Journal of Medical Education entitled "Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education" (J. Med. Educ., 48: 780-791, August 1973). There has been a heavy reprint demand for this document and many schools have indicated that they are having faculty retreats and administrative discussions regarding plans for increasing institutional responsibility for graduate education. A few institutions have developed proposals which are under active discussion. A major problem regarding moving toward assuming institutional responsibility is the issue of how to finance graduate medical education. The CCME has adopted a statement which incorporates the principal recommendations of the AAMC position statement.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services; Division of Student Studies

AAMC COMMITTEE: Graduate Medical Education Committee

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

The AAMC National Health Insurance Task Force, as part of its recommendations to the Executive Council, has proposed the creation of a national body "to determine the number and location of resident positions in the various medical specialties." National needs would govern this determination and residents in unapproved positions would be ineligible for reimbursement under national health insurance.

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Department of Institutional Development

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

1. For admission to graduate medical education all applicants (graduates of domestic and foreign medical schools) must pass a single examination.

2. Pilot programs with enrolled FMGs should explore their educational defects and ways to correct them.

3. The approval of hospital programs for graduate medical education should be based on sound educational principles and the number of positions available should not exceed to any great extent the number of graduates from United States medical schools.

4. The permanent employemnt of unqualified, unlicensed FMGs should be discontinued even in the institutional setting.

5. Pilot programs should explore the substitution of other means to render services presently provided by FMGs in graduate education programs.

PROGRESS TOWARD ACCOMPLISHMENT:

With the approval of these recommendations by the Executive Council on March 22, 1974, the FMG Task Force Report has been submitted to the AAMC constituency for reaction and comments. Ultimate implementation will depend on constituency interest and participation, and on collaboration with other agencies and organizations.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of International Medical Education

AAMC COMMITTEE:

FMG Task Force--discharged

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

The NIRMP was established in the early 50's to eliminate an increasingly chaotic competition for first-year graduate training positions. The elimination of an internship as a requirement for certain specialty residencies in the early 70's has resulted in multiple evasions of the program by both program directors and students. The problems are summarized in the article by Joseph Ceithaml, Ph.D., and Davis G. Johnson, Ph.D., "The NIRMP and Its Current Problems" (J. Med. Educ., 48: 625-629, July 1973).

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Student Programs and Services

AAMC COMMITTEE:

IV. CONTINUING MEDICAL EDUCATION

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs

AAMC COMMITTEE: CCME

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

The Association does not have a policy on recertification or relicensure. A preliminary draft of a position was reviewed by the Graduate Medical Education Committee in early March 1974. The Committee requested that further investigation be done regarding the potential effects of recertification on the day-to-day practice of medicine by physicians. The Committee is also concerned that should recertification and/or relicensure become a commonplace requirement, the demand for educational services from physicians now in practice may increase enormously; and such an increase will require that appropriate planning for expanding educational resources in this country will be needed.

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Educational Measurement & Research

AAMC COMMITTEE: Graduate Medical Education Committee

V. INSTITUTIONAL CONSIDERATIONS

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

Although in 1968 the AAMC and the AMA jointly endorsed the position that medical schools should "accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted," this position was soon afterward considered to be impossible to attain. In 1970, the AAMC, following the recommendations of its Committee on the Expansion of Medical Education (Howard Committee), modified this endorsement to propose that by 1975, medical school first year enrollment should increase to 15,000 students, and be maintained at that level. This was felt to be sufficient to overcome the shortage of physicians. (See J. Med. Educ., 46:105-116, Feb. 71)

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

1. The Health Services Advisory Committee is presently considering this problem from three perspectives:

   a.) The roles of faculty

   b.) Determination of program responsibilities for patient care and community service.

   c.) The types of governance structures that would resolve these issues.

2. The AAMC Management Advancement Program and related institutional studies are directed toward the determination of institutional objectives and organizational structure appropriate to the role of the individual academic medical center in responding to societal and community needs. Not infrequently the work of the institution team at Phase II MAP seminars has focused on specification of medical center objectives and the design of an action plan relative to achieving these objectives.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services; Department of Institutional Development; Department of Teaching Hospitals

AAMC COMMITTEE:

Health Services Advisory Committee
Management Advancement Program Steering Committee

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Teaching Hospitals; Department of Institutional Development

AAMC COMMITTEE:

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

Three specific programs have been implemented:

1. The Management Advancement Program

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

   Thus far 65 deans have participated in Phase I and 32 schools have attended Phase II. Twenty-three schools have indicated a desire to return for Phase III. The Johnson Foundation grant which supports this program has been renewed for three years.

2. Institutional Studies

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

3. Management Systems Development

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Institutional Development, Department of Program Planning and Policy Development.

AAMC COMMITTEE:

Management Advancement Program Steering Committee
Management Systems Development Liaison Committee
Management Program Coordinating Committee

VI. FINANCING OF MEDICAL EDUCATION

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

In 1970 the Executive Council appointed a Committee on the Financing of Medical Education to make more specific policy recommendations on the responsibility of the public and private sectors and students in meeting the costs of medical education. The Committee has prepared a report, "Undergraduate Medical Education: Elements--Objectives--Costs," which attempts to identify the costs of undergraduate medical education which was approved by the Executive Council in September 1973. The Committee is now developing specific recommendations on the financing of these costs for consideration by the Executive Council.

The recommendations of the Committee on Health Manpower formed the basis for the position adopted by the Executive Council on the extension of the Comprehensive Health Manpower Training Act of 1971.

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

Committee on the Financing of Medical Education

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

Committee on the Financing of Medical Education
Graduate Medical Education Committee

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC continues to support self-study through program cost finding at the individual medical schools. The Committee's report, "Undergraduate Medical Education: Elements-Objectives-Costs," (J. Med. Educ., 49:97-128, Jan. 74), has been distributed to members of the U.S. Senate and House of Representatives, members of the Administration, and key decision makers at the state level.

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development - Division of Operational Studies

AAMC COMMITTEE:

Committee on the Financing of Medical Education

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC COMMITTEE: GSA Financial Problems of Medical Students

VII. MEDICAL SCHOOL ADMISSIONS

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

A technical study, which indicated that matching is theoretically feasible, was completed in March 1973. The medical schools in California and Michigan agreed to participate in a pilot implementation of an admissions matching program, to be conducted with the selection of the 1974-75 entering class. The program is jointly sponsored by AAMC and a grant from the Henry J. Kaiser Family Foundation. In December and January, student rank order lists were mailed to the almost 16,000 individuals who had applied to at least one participating school. In mid-April, participating schools will submit rank order lists of students. The computerized match will be run shortly thereafter, and the results will be compared to the results of the actual admissions process. A report of these results, together with recommendations for further study of admissions matching, will be made to the Administrative Boards and Executive Council in June 1974.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services

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

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Educational Measurement and Research; Division of Student Studies

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services; Office of Minority Affairs

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Institutional Development

AAMC COMMITTEE:

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs (Division of Student Studies; Division of Student Programs and Services; Division of Educational Measurement and Research); Division of Publications.

AAMC COMMITTEES:

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

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services; Division of International Medical Education

AAMC COMMITTEE:

VIII. BIOMEDICAL RESEARCH

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC policy on this matter is articulated in the document entitled, "A Policy for Biomedical Research," (J. Med. Educ., 46:689-743, Aug. 71). It is recommended that the Nation adopt a policy supporting more, rather than less, biomedical research, in full recognition of the fact that no other course can offer hope for ultimate solutions to health problems. It was further recommended that the national policy for biomedical research assure support at levels sufficient to engage all qualified brainpower and that consideration be given to expansion at a rate determined by widening research opportunities.

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has been actively concerned with ensuring adequate support for the training of biomedical research scientists. Formal policy of the Association on this issue is articulated in the document, "A Policy for Biomedical Research," (J. Med. Educ., 46:689-743, Aug. 71). In this document, it was recommended that the administration and the Congress be urged to continue federal programs providing fellowships and other stipends for advanced training in the health sciences and clinical specialties. More recently, the Committee on Biomedical Research has considered this matter and has recommended: That the Federal Government has the responsibility to support training for research in the biomedical sciences and that the support of such training should be related to the anticipated needs, variety, quality and quantity of qualified biomedical scientists. To achieve this goal, the Committee recommends that a more formal mechanism be established to examine, on an on-going basis, both the supply and demand for biomedical scientific manpower by discipline category, with the recognition of the long-lag phase between entry into the training pipeline and the emergence of an independently competent investigator.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has testified in support of training legislation, both in the House and Senate, and has worked actively toward ensuring the continuation of both federal and nonfederal support of training of biomedical research scientists. In October, 1973 the Association sponsored a research manpower workshop in Seattle, Washington and will publish the proceedings of this workshop in the Spring of 1974.

The Association in 1973 successfully brought suit to force the expenditure of Congressionally-appropriated research training funds which had been impounded by the Executive Branch.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

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

There is increasing public concern regarding the protection of human subjects in biomedical research. A bill to establish national standards for biomedical research involving human subjects is before the Congress and attempts have been made to introduce amendments to this legislation which would prohibit research on fetuses, infants and children. The DHEW is also in the process of modifying its guidelines for biomedical research involving human subjects and is in the process of adding new regulations pertaining to institutionalized subjects with limited ability to provide informed consent.

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs, Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

IX. HEALTH CARE

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC policy holds that any determination of the number of physicians needed must take into account the complex problems of physician distribution. The view of the 1970 Howard Committee report approved by the Assembly, (See - J. Med. Educ., 46:105-116, Feb. 71) that physician shortages would be met by a medical school enrollment increase to 15,000 entering students by 1975-76 is supported. This increase would give the U.S. one of the highest physician/population ratios in the world by the mid-1980's.

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

The Association adopted as its major emphasis during 1973 the improvement of education for primary care specialists. The Graduate Medical Education Committee has recommended that 50% of graduating medical students should become primary care specialists.

An ad hoc committee of the Coordinating Council on Medical Education is studying the problem of specialty maldistribution. The report of that committee, when approved by the CCME, will be forwarded to the Association for approval.

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development; Division of Operational Studies
Department of Health Service; Department of Academic Affairs

AAMC COMMITTEE:

CCME
Graduate Medical Education Committee
Task Force on Primary Care

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

Geographic maldistribution of physicians is a major public concern. There are complex interrelated reasons why physicians choose one particular societal and geographic setting over another in which to establish themselves. Generally, physicians are attracted to affluent communities which provide recreational and cultural opportunities compatible with their educational background and experience. Short-term solutions for providing physician services to both metropolitan and rural areas in need of these services have been provided through the National Health Services Corps. The NHSC depends upon financial incentives, based upon loan forgiveness, to enroll students for two-year periods of assigned services.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association supported the establishment of the NHSC in 1971; and the Committee on Health Manpower for 1974 recommended that the grant-in-aid provided for NHSC enrollees be increased from $4,000 to $6,000, and that the period of service be no more than two years without regard to the number of years' support students received during their undergraduate education. The Committee also recommended special incentives to institutions for the establishment of educational experiences in shortage areas.

PROGRESS TOWARD ACCOMPLISHMENT:

Promoting the provision of student experiences in areas of chronic physician shortage (rural and urban inner city) has not been specifically planned. Several schools have been engaged with the development of area health education centers or variances on this concept for both undergraduate and graduate students. Regionalizing medical education in this manner cannot effectively be accomplished without special financial resources. Initially, these resources must be derived from foundations, states or the Federal Government. Long-range plans for sustaining regionalized programs are essential.

The Association has supported legislation which would provide resources to enable academic medical centers to provide education and care in shortage areas. In testimony before Congress on Area Health Education Centers and similar proposals, the AAMC has emphasized the need for educational support so that students may be trained in more diversified geographic settings.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

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

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE:

Health Services Advisory Committee

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

Beginning May 1, 1974, the Department of Health Services will contract with BHRD to develop pilot physician training programs in HMOs, one component of which will explore the integration of training programs for physicians and new health practitioners. A proposal was also submitted to BHRD in March, 1974, which outlined a two-and-a-half year project to assist academic medical centers in developing, implementing and evaluating primary care training programs at both the graduate and undergraduate level. The project will involve 4-6 constituent institutions and will focus on several activities including the development of core curricula for teaching the team concept of delivering health services.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE:

Health Services Advisory Committee

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

A more explicit Association policy is being developed by the Task Force on National Health Insurance and by the Executive Council. The report of the Task Force says: "A program of national health insurance is designed to provide ready financial access to the health care system and to shift the financial burden of health care from personal expenditures to insurance coverage, thus broadening the financial base available to support health care costs. Ideally, there should be no cost-sharing under a national health insurance program. If there is cost-sharing through deductibles, co-insurance or co-payment, they should be set at minimum levels. They should not be burdensome in the aggregate; they should be waived for low income persons; they should only be high enough to avoid over-utilization. The cost-sharing should not be applicable to essential minimum services, and the cost of administering the cost-sharing program should not exceed savings from avoided over-utilization."

The report of the Task Force has been submitted to the Executive Council for review and comment.

PROGRESS TOWARD ACCOMPLISHMENT:

A recommended Association policy is currently under review by the Executive Council. The policy will form the basis of testimony before committees of the Congress considering national health insurance.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Federal Liaison; Department of Teaching Hospitals; Department of Health Services

AAMC COMMITTEE:

Task Force on National Health Insurance

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

The report of the Task Force has been submitted to the Executive Council for review and comment.

PROGRESS TOWARD ACCOMPLISHMENT:

A recommended Association policy is currently under review by the Executive Council. The policy will form the basis of testimony before committees of the Congress considering national health insurance.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Federal Liaison; Department of Teaching Hospitals; Department of Health Services

AAMC COMMITTEE:

Task Force on National Health Insurance

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

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

PRESENT STATE OF POLICY DEVELOPMENT:

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

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

PROGRESS TOWARD ACCOMPLISHMENT:

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

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE:

Health Services Advisory Committee/Subcommittee on Quality of Care

ISSUE: HOW SHOULD ABSOLUTE HOSPITAL COSTS AND THE RATE OF HOSPITAL COST INCREASE BE CONTROLLED?

Proposed regulations regarding Section 223 of P.L. 92-603 and adopted rules implementing Phase IV of the Economic Stabilization Program have established limitations on both absolute hospital costs and the rate of hospital cost increase. As proposed routine service cost will be limited on an average per diem basis depending upon the hospitals geographic location, (metropolitan, non-metropolitan), the per capita income of the state in which it is located and its size. The rate of hospital cost increase is presently regulated on a per admission basis (7.5 percent per year allowable increase); certain pass-throughs, adjustments and exceptions are provided for.

PRESENT STATE OF POLICY DEVELOPMENT:

Developed in Association's formal comments on Phase IV proposed rules (dated November 30, 1973) and comments on Section 223, P.L. 92-603 draft regulations (dated November 21, 1973).

The Association has held that proposed regulations regarding Section 223 of P.L. 92-603 and Phase IV Health Care Rules do not adequately take into consideration special features of the cost structures of teaching-tertiary care facilities. Section 223 proposed regulations seek to implement controls which do not take into account variations in patient mix and the nature and scope of services provided by hospitals. Phase IV rules do not allow for the fact that cost experiences a higher rate of increase in teaching-tertiary care hospitals as a result of the research and development activities engaged in by such facilities. In combination these regulations subject hospitals to two different control mechanisms, one controls absolute costs on a per day basis, the other controls the rate of increase by stay; when implemented together these mechanisms are incompatable.

PROGRESS TOWARD ACCOMPLISHMENT:

An ad hoc committee on the economic controls of the Council of Teaching Hospitals, chaired by Sidney Lewine has been formed to address both absolute and rate of cost increase issues. Based upon suggestions of the Association (and others) Phase IV proposed rules were significantly modified to allow for adjustment in the changes in cost and charges due to alterations in case mix. The Association has prepared an analysis of the Economic Stabilization Program as it influences hospitals -- this analysis has been forwarded to the Senate Banking and Currency Committee. It now appears that the Economic Stabilization Program will not be extended. Work is now underway to analyze data upon which the method for limiting absolute cost under Section 223 was established. Association comments on these regulations have been filed.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Teaching Hospitals

AAMC COMMITTEE:

Ad Hoc Committee on Economic Controls