



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

AGENDA  
COUNCIL OF ACADEMIC SOCIETIES  
ADMINISTRATIVE BOARD

Thursday, September 19, 1974  
9:00 a.m. - 1:00 p.m.  
1 Dupont Circle, Room 827  
1:00 p.m. - 4:00 p.m.  
CAS/COD/COTH Lunch and Joint Session  
Dupont Plaza Hotel

- I. ACTION ITEMS:
1. All action items in the accompanying Executive Council Agenda
  2. Approval of Minutes of CAS Administrative Board Meeting of June 20, 1974 1
  3. Dues: Non-payment of the Association of Teachers of Preventive Medicine 11
  4. Meeting with Executive Committee of the American Academy of Family Physicians 13
- II. DISCUSSION ITEMS:
1. Resolution from American Society for Pharmacology and Experimental Therapeutics on NBME GAP - Report in Executive Council Agenda 14
  2. Review of LCME Accreditation Process Appendix I
  3. CAS interest in the Intern Matching Plan - Letter from Dr. Henley 15
  4. The need for a new procedure for Borden Award Nominations 17
  5. American professors teaching in Mexican medical schools 20
  6. Annual Meeting Programs and Activities 21
  7. Executive Council input into Retreat agenda
- III. INFORMATION ITEMS:
1. CAS Nominating Committee Report 24
  2. Biomedical Research Committee Report
  3. Legislative Activity Report

CAS/COD/COTH JOINT SESSION  
1:00 p.m. - 4:00 p.m.

1:00 - 2:00 p.m. Lunch

2:00 - 4:00 p.m. General Session

Report of the Council of Deans

Report of the Council of Academic Societies

Report of the Council of Teaching Hospitals

Report of the Organization of Student Representatives

Report of the Chairman

Report of the President

MINUTES  
ADMINISTRATIVE BOARD  
COUNCIL OF ACADEMIC SOCIETIES

June 20, 1974

AAMC Headquarters  
Washington, D.C.

PRESENT:	<u>Board Members</u>	<u>Staff</u>	<u>Guests</u>
	Ronald W. Estabrook, Chairman (Presiding)	Michael F. Ball	**Peter Safar
	A. Jay Bollet	Connie Choate	
	David R. Challoner	William G. Cooper	
	D. Kay Clawson	**Charles B. Fentress	
	Carmine D. Clemente	**Doris A. Howell	
	Jack W. Cole	Hilliard Jason	
	Rolla B. Hill, Jr.	Mary H. Littlemeyer	
		**James R. Schofield	
		**John F. Sherman	
		**Emanuel Suter	
		August G. Swanson	

ABSENT: Board Members

Robert M. Blizzard  
\*Ernst Knobll  
\*Robert G. Petersdorf  
Leslie T. Webster

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting held March 6, 1974, 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. He participated in the Spring Meeting sponsored by the Council of Deans in Phoenix, Arizona whose topic was "Zero Institutional Growth." During the COD meeting as well as in conference calls at other times, officers of the Association held discussions on National Health Insurance testimony.

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\* Ex Officio  
\*\* For a part of the meeting

### III. Action Items\*

#### A. Ratification of LCME Accreditation Decisions

ACTION: A motion to ratify LCME Accrediting Decisions (as set forth in the Executive Council Agenda Book on page 15) was approved by the CAS Administrative Board with two for the motion and four abstaining due to insufficient information on which to make a decision.

The action reported above came at the conclusion of an extensive discussion of the accreditation process, during which Dr. James R. Schofield, who heads this activity for the AAMC, joined the Board. Dr. Schofield reviewed at length the situation, including the delicate balance that exists between AAMC and the AMA in their activity through the Liaison Committee on Medical Education, the schedule for the upcoming year starting July 1 (30 visits), the implications of failure to receive accreditation on an institution.

The Board expressed a number of concerns, one of which pertained to the composition of the visiting team with particular reference to perceived inadequacy of one basic scientist. Dr. Clemente said he had names of 45 anatomists who have expressed their willingness to serve on accreditation visits.

By letter Dr. Petersdorf set forth some concerns he had about recommendations. The general consensus was that Dr. Petersdorf's feelings were not supported by adequate objective data to alter the recommendations.

One concern that seemed to be shared by all was the limited information available to the Board on which they were asked to take action. When it became apparent, as explained by Dr. Schofield, that distribution of the site visit report to the entire Board would complicate the picture from the standpoint of equal distribution to both sponsoring agencies, Dr. Estabrook requested that whenever any controversy surrounds a recommendation, details should then be given to the Board.

It was felt that a need exists by and large for intrainstitutional evaluation mechanisms to permit the medical school to judge how well it is doing, i.e. is its educational program meeting its objectives. Most of the examinations measure how well the student has done, i.e. the student, not the program, is examined.

Dr. Schofield was receptive to Dr. Estabrook's recommendation that a study group be established to work with the LCME to further explore enhancing the CAS input into the LCME.

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\* The CAS Administrative Board took action first on items in the Executive Council agenda, followed by action on items in the CAS Administrative Board agenda.

B. Election of Institutional Members

ACTION: The CAS Administrative Board voted unanimously to approve for full Institutional Membership in the AAMC the four medical schools listed in the Executive Council Agenda on page 18.

C. COTH Membership

ACTION: The CAS Administrative Board approved unanimously the hospitals approved for COTH Membership as listed on page 19 in the Executive Council Agenda.

D. Proposed Change on CCME Bylaws

ACTION: The CAS Administrative Board voted unanimously to approve the proposed change in the CCME Bylaws as set forth in the Executive Council Agenda on page 22.

E. Suggested Amendment to the AAMC Position on Foreign Medical Graduates

ACTION: The CAS Administrative Board voted unanimously to approve the suggested amendment to the AAMC position on foreign medical graduates as set forth in the Executive Council Agenda on pages 23-24 with one additional modification: to delete in line 9 the phrase "(or the FLEX examination could)".

The CAS discussed the amendment that had been introduced by the COD. There was general concern about the introduction of the possibility that the FLEX examination be used as a qualifying examination on a national basis.

F. Proposal for the Establishment of a Liaison Committee on Continuing Medical Education

ACTION: The CAS Administrative Board voted unanimously to approve the proposal for the establishment of a Liaison Committee on Continuing Medical Education as set forth in the Executive Council Agenda on page 28.

G. Statement on the Responsibilities of Institutions, Organizations, and Agencies Offering Graduate Medical Education

ACTION: The CAS Administrative Board voted unanimously to approve the Statement on the Responsibilities of Institutions, Organizations, and Agencies offering Graduate Medical Education as set forth in the Executive Council Agenda on page 31.

H. Issues, Policies, and Programs of the AAMC (Green Book)

ACTION: The CAS Administrative Board voted unanimously to approve the proposed publication and distribution of the "Green Book" entitled Issues, Policies, and Programs of the AAMC as set forth in the Executive Council Agenda on page 33.

I. AAMC Policy Statement on New Research Institutes and Targeted Research Programs

ACTION: The CAS Administrative Board voted unanimously to approve AAMC Policy Statement on New Research Institutes and Targeted Research Programs as modified by the Board. (See Attachment A.)

J. Report of the National Health Insurance Task Force

ACTION: The CAS Administrative Board voted, with one abstention, to approve the Report of the National Health Insurance Task Force as set forth in the Executive Council Agenda on pages 36-47.

K. Report of the Ad Hoc Review Committee on the MCAAP

ACTION: The CAS Administrative Board voted unanimously to approve the Report of the Ad Hoc Review Committee on the MCAAP as set forth in the Executive Council Agenda on pages 49-53.

L. Report of the Committee on the Financing of Medical Education

ACTION: The CAS Administrative Board voted, with one abstention, to approve the Report of the Committee on the Financing of Medical Education (Charles C. Sprague, M.D., Chairman) dated May, 1974.

M. AAMC Statement on Moonlighting by House Officers

ACTION: The CAS Administrative Board voted to approve the AAMC Statement on Moonlighting by House Officers as set forth in the Executive Council Agenda on page 56 with a modification to delete items 2(c) and 2(d) with four votes for, one against, and one abstaining.

After a great deal of debate, the CAS Administrative Board decided that in order to approve the statement recommended by which primary care institutions should monitor and control the practice of moonlighting by house officers, they would need to delete from the statement the recommendation that called for evaluating the needs of the community and the financial need of the individual.

N. Program for Visiting Professors Emeriti

ACTION: The CAS Administrative Board voted unanimously to approve the proposed program for visiting Professors Emeriti.

Dr. Howell joined the Council to report on the proposal to develop a program for visiting Professors Emeriti who have retired due to mandatory age requirements but who might still be available to make valuable contributions in a variety of situations such as interim faculty in new schools not yet staffed or as faculty for professors on sabbatical leave. She also reviewed the opinions of the COD polled on this proposal.

The Visiting Professors Emeriti program will develop in a three-pronged approach:

1. Responsibility for the individual programs will rest with the host medical school.
2. Responsibility for the quality of contribution and personal commitment to the concept and contract will lie with the individual volunteer faculty scholar.
3. Responsibility for coordinating administrative details, and evaluation of overall benefits and problems will fall under the aegis of the AAMC, which will act as catalyst and clearinghouse.

O. New Applications

ACTION: The application for membership of the Society for Critical Care Medicine was approved for recommendation to the full Council with one vote cast against the motion.

Dr. Peter Safar, past president of the Society for Critical Care Medicine, joined the Board to support the application for membership of the Society for Critical Care Medicine in the Council of Academic Societies.

P. Future Meetings

1. Regularly Scheduled Meetings

ACTION: Accordingly, the Chairman was authorized, as an experiment, to invite six selected societies to the next regularly scheduled meeting of the CAS Administrative Board.

In March the CAS Administrative Board voted unanimously to invite on a rotating basis representatives from the member societies to meet with the Board at its quarterly meetings.

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P. Future Meetings

1. Regularly Scheduled Meetings (con't)

This item was reconsidered by the Board from the standpoint of the mechanism for implementation in terms of the paucity of meetings annually (four) and the large number of eligible official representatives (60 x 2 = 120+). Dr. Clawson suggested governance guidelines which the Board found attractive and feasible. Under these guidelines, official representatives of the societies would be invited to attend at their own expense; subsequent to notice of their intent to attend (submitted in writing), agenda materials would be mailed to them to which they would be entitled to respond in writing; also they would be entitled to submit in writing any items they might wish to submit for consideration on future agenda; such guests would be permitted neither voice nor vote in the meetings.

2. Dinner Meeting with COTH Advisory Board

In March the CAS Administrative Board voted unanimously to invite the COTH Administrative Board to a dinner meeting on the evening of June 19, prior to this meeting, to discuss mutual interests. This was done, and the CAS Administrative Board found the evening was so productive and effective that they wished to invite the COTH Administrative Board to a similar meeting the evening before the next meeting.

3. COD-COTH-CAS Joint Meeting

ACTION: At Dr. Estabrook's invitation, Drs. Challoner and Clawson volunteered to be responsible for assisting with finalization of the programs, including planning and recruiting of program participants.

A tentative agenda for the COD-COTH-CAS Joint Meeting to be held November 13 in conjunction with the AAMC Annual Meeting was distributed. (See Attachment B)

4. Spring Meeting

Despite Dr. Estabrook's personal letters of invitation to 260 persons to attend the CAS Annual Spring Meeting held at the Mayflower Hotel in Washington, D.C., a disappointing number were recorded in attendance. On the day of the Annual Business Meeting, March 7, 46 individuals, representing 38 of the 60 member societies, were present. On the second day, the situation was even less impressive. In view of this continuing trend, i.e. the 1974 showing was not atypical of earlier spring meetings, it was agreed that no plans should be made for a Spring Meeting in 1975.

IV. DISCUSSION ITEMS

A. Proposed Ethics Seminar

The Board reviewed the proposal for a one-day workshop on Ethical Aspects of Medical Care to be jointly sponsored by the AAMC and the National Academy of Sciences on September 18. The conflict with the Jewish holiday September 17 was noted, but no one present was in a position to judge the extent to which this would affect attendance. June was suggested as an alternative, but there seemed to be limited interest in either possibility.

B. Proposed Seminar for Medical Writers

Charles Fentress discussed this proposal which was outlined in the CAS Administrative Board agenda on pages 10-11. This seminar is tentatively planned for October 17-18-19 in Tucson, Arizona. The Board's reaction to this development was very favorable.

V. INFORMATION ITEMS

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

The Board received a copy of this document which had been drafted by the Biomedical Research Committee for presentation to the Executive Council at its fall meeting. The Board was invited to submit its reactions to this paper to Dr. Ball for consideration in the next draft.

B. Injuries Sustained During Research: Draft Questionnaire

The above draft questionnaire was distributed to the Board for critique. This is to elicit data from the deans for the past five years.

C. National Research Training and Protection of Human Research Subjects Act of 1974

A copy of the above Conference Report (to accompany H.R. 7724) dated June 10, 1974 was distributed to the Board for its information.

D. Proposed AMA Guidelines for House Staff Contracts

The above document was distributed to the Board for its information.

E. Resolution of American Association of Chairmen of Departments of Psychiatry

The Board received this resolution dated May 5, 1974 regarding the Board's intention to reinstate the requirement of an experience of one year (comparable to a year of internship) of postdoctoral education prior to the psychiatric residency experience.

#### IV. DISCUSSION ITEMS (con't)

##### F. Other Reports

The Board received the following reports:

1. Findings of New Study of Early Decision Plan, dated May 7, 1974, (pages 17-18 in CAS Administrative Board Agenda) from Davis G. Johnson.
2. AAMC/AADS/NLM Educational Materials Project, dated June 20, 1974 from William G. Cooper.
3. Primary Care Institute by August G. Swanson.
4. AAMC Task Force on GAP Report by Doris Howell.

##### G. New Business

The Board noted with regret the resignations of Ms. Connie Choate, Secretary to Dr. Swanson, and Dr. Michael Ball, Director of the Division of Biomedical Research Policy. The contributions of each to the programs of the Council were felt to be of inestimable value. Ms. Choate's resignation is effective June 28, 1974. Dr. Swanson requested suggestions for a suitable successor to Dr. Ball for a 2-3 year tenure. Dr. Ball would like to be relieved of his post as soon as possible, certainly by January 1, 1975.

##### V. Adjournment

The business meeting\* was adjourned at 3:40 p.m.

MHL:aw

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\* A joint dinner meeting with the COTH Administrative Board at the Dupont Plaza Hotel on June 19, 1974 preceded the business meeting.

During luncheon on June 20, 1974, a legislative report by AAMC President Cooper and staff was presented in a joint session of the CAS and COD Administrative Boards.

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 *may have to be modified periodically to accomplish* (is satisfactory for all the) perceived goals of the NIH. Nevertheless, (Therefore) the Association strongly believes that *fragmentation* (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 *categorical disease* 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 *is available*.
2. There should be a clear indication in the development and implementation of *the* (a) specific legislative program that such a program shall not occur *to* (at) the *detriment* (expense) of other *essential* 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.

## AGENDA

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.*

July 22, 1974

William H. Marine, M.D., M.P.H.  
Professor  
Secretary-Treasurer, Assn. of Teachers  
of Preventive Medicine  
Emory U. School of Medicine  
69 Butler Street, S.E.  
Atlanta, Georgia 30303

Dear Dr. Marine:

I am responding to your letter of July 15 regarding annual dues payment for membership in the Council of Academic Societies of the Association. Your request for a variance from the newly established dues rates for member societies will be referred to the Administrative Board of the Council at its next meeting, September 19, 1974.

The Administrative Board recognizes that several societies have had dues structures which make the changed rate for membership in the Council awkward.

Sincerely yours,

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

cc: Michael F. Ball, M.D., AAMC  
Ronald W. Estabrook, M.D., Chairman, CAS  
(with incoming correspondence)

J. Trevor Thomas, AAMC

AGS/ms

EMORY UNIVERSITY SCHOOL OF MEDICINE

THOMAS K. GLENN MEMORIAL BUILDING  
69 BUTLER STREET, S. E. ATLANTA, GEORGIA 30303

DEPARTMENT OF PREVENTIVE MEDICINE  
AND COMMUNITY HEALTH

July 15, 1974

Association of American Medical Colleges  
Suite 200  
One DuPont Circle, NW  
Washington, D.C. 20036

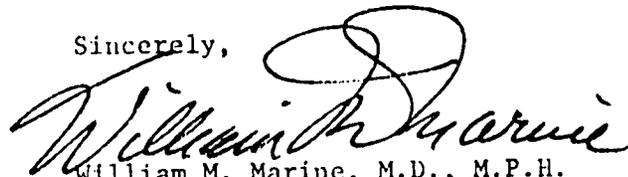
Re.: Invoice No. 72502

Dear Sirs:

Enclosed is a check for \$100 toward payment for the 1974-75 Membership Dues for the Association of Teachers of Preventive Medicine (ATPM) in the Council of Academic Societies (CAS). The executive committee has instructed me to do this in an effort to seek some kind of continuing association for the ATPM in the CAS despite the financial inability of our organization to pay the \$1000 annual dues. Our annual dues of \$10 per member makes the \$1000 an unrealistic figure.

We are most anxious to maintain some sort of continuing relationship in the CAS because we believe it to be playing an increasingly important role as a sounding board and coordinating organization for academic medicine at this critical time in our history.

Sincerely,



William M. Marine, M.D., M.P.H.

Professor

Secretary-Treasurer, Association  
of Teachers of Preventive Medicine

WMM:uli

Enclosure

CC. Dr. Joseph Stokes, President, ATPM  
Dr. Robert Huntley, President Elect, ATPM

# AMERICAN ACADEMY OF FAMILY PHYSICIANS

1740 WEST 92ND STREET . KANSAS CITY, MISSOURI 64114

ROGER TUSKEN  
EXECUTIVE DIRECTOR

July 15, 1974



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

Dear Dr. Swanson:

Belatedly, I am following up on your cordial letter to me of February 27.

It was discussed with our officers and they were of the opinion that a presentation before the Society of Teachers of Family Medicine or the conference on Research in Medical Education would not accomplish the purposes desired in our request to present a report on family medicine at the AAMC annual meeting.

We are still desirous of continuing the liaison established with your Executive Committee last year and our Executive Committee is most anxious to host a similar meeting for your Executive Committee. You advised that you were exploring the possibility of arranging a meeting between the Administrative Board of the Council of Academic Societies and our Executive Committee. Has anything developed further in this regard?

Sincerely

A handwritten signature in cursive script that reads "Roger Tusken".

Roger Tusken

rt:hc:jr

AMERICAN SOCIETY FOR PHARMACOLOGY  
AND EXPERIMENTAL THERAPEUTICS, INC.

*Handwritten:* → *cto*  
*O. Howell -*  
*Sanitar CAS Admin Bldg. 4/28/74*

Office of the President  
Department of Pharmacology  
The George Washington University Medical Center  
2300 Eye Street, N.W.  
Washington, D.C. 20037  
Tel: (202) 331-6841



*Councillors*  
E. Tsong Way  
Steven E. Mayer  
Eva King Killam

June 28, 1974

*Council*  
H. GEORGE MANDEL, *President*  
THEODORE M. BRODY, *President-Elect*  
JOHN J. BURNS, *Past President*  
BERT N. LA DU, JR., *Secretary-Treasurer*  
ALLAN H. CONNEY, *Secretary-Treasurer Elect*  
NORMAN WEINER, *Past Secretary-Treasurer*

*ex officio*  
Edward J. Cafruny, *Chairman*  
Board of Publications Trustees

*Executive Officer*  
Ellsworth B. Cook

I wish to transmit to you a resolution initiated by our Committee on Educational and Professional Affairs, approved by our Council, and supported overwhelmingly by our membership at the business meeting in Atlantic City, N.J. on April 9, 1974.

RESOLUTION

Whereas the National Board of Medical Examiners has proposed substantial changes in the examining procedures for health professionals that eliminates direct examination in the basic sciences

and Whereas Pharmacology is the basis of rational and effective drug therapy

and Whereas the basic science disciplines including Pharmacology, have goals of preparing students to maintain their professional competence under evolving circumstances of practice

Be it resolved that:

Standardized national examinations should continue to devote separate attention to the disciplinary content of the basic medical sciences

Standardized national examinations should direct substantial attention to evaluating student understanding of fundamental principles and concepts of basic science discipline as well as evaluating competence in applying these principles and concepts to current therapeutic practice and direct patient care

Every level of examination and re-examination of the health professional should give due attention to fundamental principles and concepts of basic science disciplines and their relationships to practice

Disciplinary specialists in the basic sciences should have primary responsibility for the development of the content of examinations in their areas

*H. George Mandel*  
H. George Mandel, Ph.D.  
President

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August 6, 1974

Keith S. Henley, M.D.  
Professor of Internal Medicine  
University of Michigan  
Medical School  
Ann Arbor, Michigan

Dear Dr. Henley:

Your letter of July 19, 1974 addressed to Dr. Charles Sprague, former Chairman of the AAMC, has been referred to me for reply.

The issue that you raise is a complex one which I would like to refer to the Administrative Board of the Council of Academic Societies for consideration. The Administrative Board includes among its members, chairmen of many of the clinical departments, and it would seem appropriate that the CAS take a leadership role in attempting to approach this problem.

The CAS Administrative Board meets on Thursday, September 19, 1974 and I shall advise you of their action shortly after that meeting.

Sincerely yours,

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

MFB:ms

JUL 24 1974

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THE UNIVERSITY OF MICHIGAN  
MEDICAL SCHOOL  
ANN ARBOR, MICHIGAN

DEPARTMENT OF INTERNAL MEDICINE  
Section of Gastroenterology  
Gastroenterology Research Unit

July 19, 1974

Dr. Charles C. Sprague  
President  
Association of American Medical Colleges  
1 Dupont Circle  
Washington, D.C. 20030

Dear Doctor Sprague:

In company with many others, we are deluged with applications for subspecialty training, in this case in Gastroenterology. The number of openings are severely limited but we would like to give everybody a fair chance. Accordingly, we send each applicant an informative letter and an application form which includes the names of three individuals to whom reference may be made. We receive the required responses, and, with few exceptions, "If you have read one, you have read them all." Many of these letters have obviously been xeroxed with only the names of the recipient typed in. This may often be quite unfair to the applicant who is often inexperienced in these matters and may result in some bitterness and disappointment.

Is this not a matter which the AAMC might take an interest in? Our problem is most unlikely to be unique and the total sum of wasted effort involving all the medical schools with all their subspecialties must be substantial.

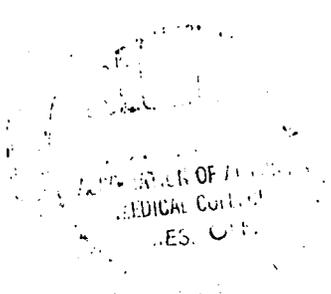
With many thanks in advance for your attention,

Yours sincerely,

*Keith S. Henley*

Keith S. Henley, M.D.  
Professor of Internal Medicine  
Physician in Charge  
Section of Gastroenterology

KSH:gkb



UNIVERSITY OF VIRGINIA

SCHOOL OF MEDICINE  
CHARLOTTEVILLE, VIRGINIA

DEPARTMENT OF PHYSIOLOGY

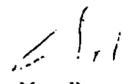
July 11, 1974

Dr. John A.D. Cooper, President  
Association of American Medical Colleges  
Suite 200, One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear John:

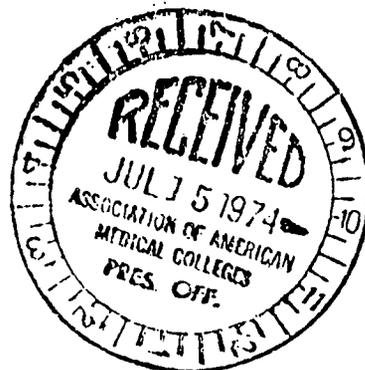
I meant to send you this when I wrote it. It is a carbon of the letter I sent to Lloyd Smith regarding my recommendations for the Borden Award. I am sending you a copy not necessarily to inform you of my preferences but to indicate my disappointment in the paucity of names of outstanding scientists submitted for the Borden Award and wondered if there is not a better mechanism for getting bigger and better input.

Sincerely,

  
Robert M. Berne, M.D.  
Chairman and Charles Slaughter  
Professor of Physiology

RMB/E

Enclosure



June 28, 1974

Dr. Lloyd H. Smith, Jr.  
Department of Medicine  
University of California  
School of Medicine  
San Francisco, California 94143

Dear Doctor Smith:

The following is my preference list for the 15 candidates submitted for the Borden Award. At the outset I might say I was terribly disappointed in the small number of names submitted, the poor distribution and the caliber. I am sure any one of us could think of a lot of other highly deserving scientists whose names were not submitted for the award. This makes me wonder whether applicants should be sought from Deans of medical schools or whether a fairly large committee should be appointed to seek out potential candidates for the award. Now that I have that off my chest, the list is as follows:

1. Everett
2. Toplin
3. Yalow
4. Kilbourne
5. Dement
6. Gottlieb
7. Hellstroms
8. Mangos
9. Preuss
10. Norman
11. Bowman
12. Reiter
13. Deinhardt and Holmes
14. Galante
15. Morrell

I hope if one of these individuals is selected it will be within the first five or possibly six listed above since I feel all of the remaining candidates are poor choices for the Borden Award.

Sincerely yours,

Robert M. Berne, M.D.  
Chairman and Charles Slaughter  
Professor of Physiology

RMB/f

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #74-9

March 22, 1974

TO: Members of the Assembly  
FROM: John A. D. Cooper, M.D., President  
SUBJECT: BORDEN AWARD NOMINATIONS

Nominations for the Borden Award in the Medical Sciences for 1974 are now open.

This award was established by the Borden Company Foundation, Inc. in 1947 and consists of \$1,000 in cash and a gold medal to be granted in recognition of outstanding clinical or laboratory research by a member of the faculty of a medical school which is a member of the Association of American Medical Colleges.

Regulations Governing the Award

1. Nominations may be made by any member of the faculty of a medical school which is a member of the Association of American Medical Colleges.
2. The Award in any year will be made for research which has been published during the preceding five calendar years.
3. No persons may receive more than one Borden Award for the same research although he/she may receive a later Award for a different research project.
4. If two or more persons who have collaborated on a project are selected for an award, the gold medal and check shall be presented to the group, and bronze replicas of the medal presented to each of the collaborators.
5. The Association may refrain from making an Award in any year in which no person reports research of the quality deserving an Award.
6. Only one Award shall be made during any one year.
7. A nominee who fails to receive the Award may be nominated for the Award for the same work in a subsequent year.
8. Materials supporting nomination should include:
  - a. Six copies of a statement covering the academic history and scientific accomplishments of the nominee.
  - b. Six copies of a reasoned statement of the basis for the nomination.
  - c. Six copies of reprints reporting the nominee's important research
9. All materials supporting nominations should be sent to me by May 15, 1974, so I can forward them to the members of the Borden Award Committee. The committee will give consideration to the nominations and make recommendations to the Executive Council of a candidate for this Award.

## U.S. Medics Now Teach In Mexican University

By LYNNE CARRIER  
Copley News Service

GUADALAJARA, Mexico

In the dusty outskirts of Guadalajara, Mexico's second-largest city, a modern university hospital is offering a new program that may well benefit its thousands of American and Mexican medical students.

Guest professors from Harvard, Stanford, the University of California and other prestigious medical schools are arriving in Mexico to participate in this pilot program. Each visiting lecturer teaches a course in his medical specialty for three to four weeks.

Known as the Block System, this in-depth specialized curriculum is currently used by a number of American medical schools.

But its adoption at the Guadalajara Autonomous University will affect the largest American student body outside of the United States.

An estimated 2,000 U.S. citizens -- roughly half the enrollment -- are studying now at the Autonomous University's School of Medicine.

The application crunch continues even though American students pay a steep \$2,000 a semester for tuition plus a \$1,000 admission fee. Ameri-

cans must also be fluent in Spanish, meet grade requirements, and obtain a student visa for the duration of studies in Mexico.

The new program is likely to enhance the university's attractiveness. Dr. Angel Leano Hospital, a beautifully designed facility boasting the best equipment available, opened for business last Feb. 4, and the Block System program went into effect immediately. Under the direction of the dean of medicine, Dr. Nestor Velasco Perez, the curriculum was carefully organized to include subjects required in Mexico.

The energetic young dean left it flexible enough to add recent medical breakthroughs over and beyond the standard requirements.

Dr. William D'Angelo, a medic from the State University of New York, was then asked to invite outstanding American professors as guest lecturers. D'Angelo had organized a similar arrangement for the Autonomous University in Mexico City, and the New York professor wooed a panoply of talented colleagues to Guadalajara as well. The university pays the visiting professors' travel and living expenses, but apart from that, the American professors donate their teaching time.



CAS-COD-COTH JOINT MEETING

AAMC ANNUAL MEETING  
Wednesday, November 13, 1974  
2:00 - 5:15 P.M.

SPECIALTY DISTRIBUTION OF PHYSICIANS

2:00 - 2:30 P.M.     *A Congressional Perception of the Problem*

Mr. Stephen E. Lawton  
Counsel for the Subcommittee on  
Public Health & Environment  
of the House Interstate and  
Foreign Commerce Committee

2:30 - 3:00 P.M.     *Redistribution of Specialty Training  
Opportunities - Options for the Private  
Sector*

Arnold S. Relman, M.D.  
Chairman, Department of Medicine  
University of Pennsylvania  
School of Medicine

3:00 - 3:30 P.M.     *Redistribution of Specialty Training  
Opportunities - Options for the Government*

Theodore Cooper, M.D.  
Deputy Assistant Secretary for Health  
Department of Health, Education and  
Welfare

3:30 - 3:50 P.M.     Intermission

3:50 - 5:15 P.M.     Panel Discussion

*The panel discussion will take the form  
of a question and answer session during  
which the following three individuals  
will direct questions to the above  
speakers.*

Chairman: Julius R. Krevans, M.D., Dean  
University of California, San Francisco  
School of Medicine

Robert A. Chase, M.D., Chairman  
Department of Anatomy  
Stanford University School of Medicine

Charles B. Womer, Director  
Yale-New Haven Hospital

COUNCIL OF ACADEMIC SOCIETIES

Activities Schedule  
AAMC Annual Meeting  
November 11 - 16, 1974

MONDAY, NOVEMBER 11, 1974

ROOM

8:00 a.m. - 5:00 p.m. Individual Society Meetings

TUESDAY, NOVEMBER 12, 1974

9:00 a.m. - 12:00 Noon Quality Assurance and PSROs  
CAS/COTH Joint Program Waldorf

12 Noon - 1:30 p.m. CAS Administrative Board Luncheon\*

2:00 p.m. - 5:00 p.m. CAS Business Meeting Waldorf

6:00 p.m. - 7:30 p.m. AAMC General Reception Grand Ballroom

8:00 p.m. - 11:00 p.m. Seminar on Foreign Medical Graduates Williford B & C

WEDNESDAY, NOVEMBER 13, 1974

9:00 a.m. - 12:00 Noon Plenary Session  
Chairman's Address International  
Ballroom

2:00 p.m. - 5:00 p.m. Specialty Distribution of Physicians  
CAS/COD/COTH Program International  
Ballroom

6:00 p.m. - 7:00 p.m. AAMC General Reception Grand Ballroom

THURSDAY, NOVEMBER 14, 1974

9:00 a.m. - 12 Noon Plenary Session  
Alan Gregg Memorial Lecture International  
Ballroom

1:00 p.m. - 4:00 p.m. Assembly Williford

4:30 p.m. - 6:00 p.m. Minority Affairs Program Williford

6:00 p.m. - 7:30 p.m. AAMC General Reception Grand Ballroom

\*Tentative

CAS NOMINATING COMMITTEE FINAL REPORT

For Election To Membership On Administrative Board

CHAIRMAN-ELECT

Ernst Knobil, Ph.D.  
Chairman, Department of Physiology  
University of Pittsburgh  
School of Medicine  
Pittsburgh, Pennsylvania 15213

Rolla B. Hill, Jr., M.D.  
Chairman, Department of Pathology  
State University of New York  
Upstate Medical Center  
766 Irving Avenue  
Syracuse, New York 13210

BASIC SCIENCE

(Vote for Two)

William J. Rutter, Ph.D.  
Chairman, Department of Biochemistry & Biophysics  
University of California, San Francisco  
Room S960, San Francisco Medical Center  
San Francisco, California 94122

Harold S. Ginsberg, M.D.  
Chairman, Department of Microbiology  
Columbia University  
College of Physicians and Surgeons  
630 W. 168th Street  
New York, New York 10032

F. Marion Bishop, Ph.D.  
University of Oklahoma  
Health Sciences Center  
800 NE 13th Street  
Oklahoma City, Oklahoma 73190

Robert M. Berne  
Chairman, Department of Physiology  
University of Virginia  
Medical School  
Charlottesville, Virginia 22901

CLINICAL SCIENCE

(Vote for Two)

Dr. David R. Challoner  
Assistant Chairman  
Department of Medicine  
Indiana University Medical Center  
1100 West Michigan Street  
Indianapolis, Indiana 46202

James B. Snow, Jr., M.D.  
Chairman of Otorhinolaryngology and  
Human Communication  
University of Pennsylvania  
School of Medicine  
Philadelphia, Pennsylvania 19104

Daniel Freedman  
Chairman of Psychiatry  
University of Chicago  
Chicago, Illinois 60637

Thomas Oliver  
Chairman of Pediatrics  
University of Pittsburgh  
School of Medicine  
Pittsburgh, Pennsylvania



APPENDIX I

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

August 27, 1974

MEMORANDUM

TO: The Administrative Boards of the COD, CAS and COTH

FROM: Joseph A. Keyes, Director, Division of Institutional Studies

SUBJECT: Background Material for Administrative Board Examination of LCME Accreditation Process

The purpose of this paper is to assist the Administrative Boards in their examination of the process of undergraduate medical education accreditation. It provides a brief description of the LCME and its role in accreditation; it then reviews three facets of accreditation--the standards, the evaluators, and the procedures for evaluation. Finally, it summarizes the results of the process for the year 1973-74, and lists the actions of the LCME for the past three academic years.

Since 1942, accreditation of educational programs of medical education leading to the M.D. degree has been conducted through the agency of the Liaison Committee on Medical Education (LCME). This committee was formed to facilitate the cooperation of the AMA and the AAMC in accomplishing their common goal of enhancing and maintaining the quality of medical education. Prior to that date, the activities of the two associations were conducted independently. The AMA's Council on Medical Education, one of four standing committees of the House of Delegates, was organized in 1904, began inspecting medical schools in 1906, and assisted in the Carnegie Foundation study of 1909 which resulted in the "Flexner Report." The AAMC, first organized in 1876 and reorganized in 1890, set standards for membership as a means of upgrading the quality of medical education and has published its list of member schools since 1896.

The LCME is currently a 15-member committee constituted as follows: 6 are appointed by the AAMC Executive Council; 6 are members of the AMA Council on Medical Education; 2 are "public representatives" selected by the committee itself; 1 is a "federal representative" designated by the Secretary of Health Education and Welfare on the invitation of the Liaison Committee. Thus the process of accreditation involves the community of practicing physicians, the academic community and the public.

Accreditation, originally a kind of voluntary peer review signifying that an approved program had received public recognition as meeting certain minimal standards of quality, has become an

integral part of the process of two governmental activities, licensure and funding of programs. Graduation from an approved program is a condition of eligibility for professional licensure in many states. Approval by an agency recognized by the Commissioner of Education is a statutory prerequisite of eligibility for an institution's receipt of federal funds under many programs. The states vary in their licensure provisions, some specify the approving agency in the medical practice act, some leave this to the board of medical examiners; some specify the AMA, some the AAMC, and some the LCME. The current practice of both the AMA and the AAMC has been to meet these various requirements by delegating authority for making the accreditation decisions to the LCME subject to a somewhat pro forma ratification by the sponsoring agencies. This approach, combined with the specific review and recorded opinion of each survey report by each member of the cognizant body of both sponsoring agencies (the Executive Council of the AAMC and the Council on Medical Education of the AMA) serves to preserve the early and immediate involvement of the practicing community, the academic community and the public in an administratively manageable fashion.

The committee receives staff support from both the AMA and the AAMC, the secretariate alternating between the two associations annually. The professional staff of the two associations serve as secretaries on site visit teams. The expenses of the committee are borne equally by the two parent associations.

1. Standards. The Functions and Structure of a Medical School, developed by the LCME and adopted in 1972 by the AAMC Assembly and in 1973 by the AMA House of Delegates, is the basic policy document of the LCME.

The objectives of the document are set out in the introduction as follows:

"It is intended that this material be used to assist in attainment of standards of education that can provide assurance to society and to the medical profession that graduates are competent to meet society's expectations; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated.

The concepts expressed here will serve as general but not specific criteria in the medical school accreditation process. However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education."

Thus, this document avoids setting out detailed requirements such as student-faculty ratios, number of books in the library, or number of beds per student. Its purpose is to set out some basic guidelines within which a high degree of professional judgment can be exercised.

In order to assist site visitors in their evaluation, a check-list derived from this document has been developed. (Attachment I) This check-list, which is given to each survey team member, sets out a series of discrete statements expressing the explicit expectations of the LCME contained in Functions and Structure. With respect to each, the question is asked, "Does the school conform?"

The LCME is presently considering these procedures with a view to answering the following questions. Are these standards adequate and appropriate? If not, in what respect are they deficient? Are they in the proper form? Are they understood by the academic community, by the evaluators, by the public?

Do these standards meet the criteria set forth in the "Criteria for Recognition of Accrediting Agencies and Associations of the Office of Education?" (Attachment II)

Do these standards require further elaboration after the manner of the Southern Association of Colleges and Schools? (Attachment III, excerpt of the research standard from that Association's 27-page brochure.)

2. The Evaluators. Each institution surveyed is evaluated through a process involving multiple levels of review. After review by the institution itself, the first and key review is done by the survey team which visits the school.

Each team is made up of four persons, two selected to represent the AMA and two, the AAMC. The team chairman represents one association, the team secretary is a staff member of the other. The teams are selected on a preliminary basis at a conference held prior to the academic year of the survey between the staffs of the AMA and the AAMC responsible for the operation of the LCME. Every effort is made to select a team with a balance of experience and expertise best suited to evaluate each institution. Where particular problem areas are known to exist, the team is constituted with an eye to the problems, and evaluators with skills viewed as particularly relevant to an understanding of such problems are requested to serve on the team.

Characteristically, the AMA selects a practicing clinician and an administrator as its representatives, frequently choosing from among the members of the CME and its Advisory Committee. The AAMC, having access to basic scientists and hospital administrators, frequently selects such persons to represent it, but relies heavily on deans and clinical faculty members as well. The final composition of the teams is, of course, dependent upon the availability of the prospective team members on the survey dates and their willingness to serve. It is also subject to their acceptability to the institution, though this has never proved to be a significant problem. The chief problem in composing the teams is acquiring the agreement to serve on the team from those identified as appropriate evaluators.

Attachment IV is a listing of those who have served as site visitors over the past three years, along with a somewhat simplified identification of their roles.

The following questions are posed. Have appropriate visitors been selected? Are there additional qualified people who should be asked to serve? How should the pool of visitors be identified? Should any of the visitors be disqualified? Is the process of selecting the team appropriate? If not, how should it be modified?

3. The Procedures. Each institution to be accredited is contacted several months in advance of the anticipated visit and an acceptable date is agreed upon. An extensive presurvey questionnaire is forwarded to the school with a request that it be completed in time for the site visit team to review approximately a month in advance of the visit. The team secretary, after consultation with the team chairman, negotiates an appropriate schedule of interviews with a designated representative of the school. Attachment V is a sample schedule. After the visit, the survey report is prepared by the team secretary, reviewed and revised by the team members, sent to the dean of the institution visited for correction of factual errors, and then distributed to the 54 members of the LCME, the AAMC Executive Council, the AMA Council on Medical Education (CME) and the CME Advisory Committee on Undergraduate Medical Education. A ballot accompanies the report and each of the reviewers is requested to provide his recommendation to the LCME on two matters: a) whether to accept the report, and b) whether to approve the team's recommendations. A composite vote sheet is prepared for the LCME agenda book which displays each reviewer's vote, recommendations and comments. (See Attachment VI) This material is taken into account as the LCME deliberates on the final action to be taken. Frequently, especially where the decision is a difficult one, a member of the team is present to respond to questions about the report or the institution.

The following tables summarize the results of this process for the 22 reports on which there has been final LCME action during the past year:

<u># of Reports</u>	<u>·Votes not to Accept</u>
9	0
8	1
1	2
2	3
1	4
1	8 (of 30)
<u>22</u>	

Thus, out of 54 possible votes on each report, and an average of about 35 actual votes, 17 of 22 reports received either unanimous acceptance or one dissenting vote; only one received over 10% negative votes of the total panel; two received over 10% negative votes of those actually voting. If there is widespread dissatisfaction over the quality of the reports, these vote sheets do not reflect it.

The second question on the advisory ballot, whether to approve the team recommendation, produces a greater level of disagreement as displayed in the following table:

<u># of Reports</u>	<u>Dissenting Votes</u>
6	0
4	1
2	2
1	3
1	4
3	5
2	6
1	8
1	9
1	22
<u>22</u>	

Thus about half of the reports had two or fewer votes dissenting from the team recommendation. A more complete display of the relationships between the team recommendations, the ballot responses and the final LCME action appears as Attachment VII.

4. The Results. A review of the final LCME decisions, with respect to these 22 schools, discloses the following:

A. Regular Accreditation Actions. In 17 cases the LCME action was the same as the team recommendation. In one case an additional requirement of a progress report was imposed. One school received a four-year approval and was required to submit a progress report in contrast to the team's recommended seven-year approval. In one case the team's recommendation was accepted with an increase in the maximum number of students permitted to be matriculated, in another this number was decreased by the LCME from that recommended by its survey team. One decision was deferred.

B. New VA-Medical Schools (P.L. 92-541 subchapter I). The LCME acted upon the request of four schools for a letter of reasonable assurance of accreditation (LRA) to provide eligibility for funding under the new VA-Medical School program with the following results:

<u># of Schools</u>	<u>Team Recommendation</u>	<u>LCME Action</u>
1	Yes	Yes
1	Yes	No
2	No	No

C. VA-Assistance to Existing Schools, VA (P.L. 92-541 subchapter II). Twenty-four schools requested LRA's to meet the eligibility requirement for the subchapter II VA assistance.

These were reviewed by a Task Force of the LCME prior to LCME action. Sixteen were recommended for approval and eight for disapproval. The LCME accepted all of these recommendations.

D. Summary of LCME Activities and Actions.

i. 1971-72 LCME Activities and Actions

32 Medical schools surveyed  
10 Full accreditation for a period of seven years  
7 " " " " " " five "  
4 " " " " " " three "  
5 " " " " " " two "  
6 Provisional accreditation  
2 Letters of reasonable assurance granted  
9 Schools requested and received staff consultation visits

ii. 1972-73 LCME Activities and Actions

34 Medical Schools surveyed  
9 Full accreditation for a period of seven years  
8 " " " " " " five "  
5 " " " " " " three "  
7 " " " " " " two "  
5 Provisional accreditation  
7 Proposals to establish medical schools brought to the attention of LCME  
2 Letters of Reasonable Assurance granted  
1 School placed on "open probation"  
19 Schools submitted progress reports for LCME consideration  
6 Schools requested and received staff consultation visits

iii. 1973-74 LCME Activities and Actions

\*39 Medical Schools surveyed  
10 Full accreditation for a period of seven years  
1 " " " " " " four years  
1 " " " " " " three "  
6 " " " " " " two "  
2 " " " " " " one year  
4 Provisional accreditation  
4 Proposals to establish medical schools brought attention of LCME  
1 Letter of Reasonable Assurance issued VA P.L. 92-541 subchapter I

\*Not all the surveys conducted during 1973-74 have been acted upon by LCME.

1973-74 LCME Activities and Actions (continued)

- 3 Letters of Reasonable Assurance denied VA P.L. 92-541 subchapter I
- 9 Schools submitted progress reports for LCME consideration
- 5 Schools requested and received staff consultation visits
- 16 Letters of Reasonable Assurance issued VA P.L. 92-541 subchapter II
- 8 Letters of Reasonable Assurance denied VA P.L. 92-541 subchapter II

## LIAISON COMMITTEE ON MEDICAL EDUCATION

Check List - For use by members of Medical School Survey Teams.

Statements are derived from Functions and Structure of a Medical School (1973). Does the school conform to the statement?

DEFINITION AND MISSION	Yes	No
1. A medical school IS an aggregation of resources that have been organized as a definable academic unit to provide the full spectrum of education in the art and science of medicine in not less than 32 months, culminating with the award of the M.D. degree.	___	___
2. The educational program MUST be sponsored by an academic institution that is appropriately charged within the public trust to offer the M.D. degree.	___	___
3. The principal responsibility of the medical school IS to provide its students with the opportunity to acquire a sound basic education in medicine and also to foster the development of life-long habits of scholarship and service.	___	___
4. A medical school IS responsible for the advancement of knowledge through research.	___	___
5. Each school IS responsible for development of graduate education to produce practitioners, teachers, and investigators, both through clinical residency programs and advanced degree programs in the basic medical sciences.	___	___
6. Another IMPORTANT role for the medical school is participation in continuing education aimed at maintaining and improving the competence of those professionals engaged in caring for patients.	___	___
7. As a central intellectual force within the center, the medical school SHOULD identify those needs that it might appropriately meet and create programs consistent with its educational objectives and resources to meet them.	___	___
8. A medical school SHOULD develop a clear definition of its total objectives, appropriate to the needs of the community or geographic area it is designed to serve and the resources at its disposal.	___	___
9. When objectives are clearly defined, they SHOULD be made familiar to faculty and students alike.	___	___
10. Schools SHOULD be cautious about overextending themselves in the field of research or service to the detriment of their primary educational mission.	___	___

APPROVED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION ON MARCH 28, 1973.

EDUCATIONAL PROGRAM

Yes No

- 1. Each student SHOULD acquire a foundation of knowledge in the basic sciences that will permit the pursuit of any of the several careers that medicine offers. \_\_\_ \_\_\_
- 2. The student SHOULD be comfortably familiar with the methods and skills utilized in the practice of clinical medicine. \_\_\_ \_\_\_
- 3. 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. \_\_\_ \_\_\_
- 4. (Instruction) SHOULD foster and encourage the development of the specific and unique interests of each student by tailoring the program in accordance with the student's preparation, competence, and interests by providing elective time whenever it can be included in the curriculum for this purpose. \_\_\_ \_\_\_
- 5. Attention SHOULD also be given to preventive medicine and public health, and to the social and economic aspects of the systems for delivering medical services. \_\_\_ \_\_\_
- 6. Instruction SHOULD stress the physician's concern with the total health and circumstances of patients and not just their diseases. \_\_\_ \_\_\_
- 7. Throughout, the student SHOULD be encouraged to develop those basic intellectual attitudes, ethical and moral principles that are essential if the physician is to gain and maintain the trust of patients and colleagues, and the support of the community in which the physician lives. \_\_\_ \_\_\_

ADMINISTRATION AND GOVERNANCE

- 1. A medical school SHOULD be incorporated as a nonprofit institution. \_\_\_ \_\_\_
- 2. Whenever possible it SHOULD be a part of a university . . . \_\_\_ \_\_\_
- 3. If not a component of a university, a medical school SHOULD have a Board of Trustees composed of public spirited men and women having no financial interest in the operation of the school or its associated hospitals. \_\_\_ \_\_\_
- 4. Trustees SHOULD serve for sufficiently long and overlapping terms to permit them to gain an adequate understanding of the programs of the institution and to function in the development of policy in the interest of the institution and the public with continuity and as free of personal and political predilections as possible. \_\_\_ \_\_\_

Administration and Governance (continued)

- |  | Yes | No |
|--|-----|----|
| 5. Officers and members of the medical school faculty SHOULD be appointed by, or on the authority of, the Board of Trustees of the medical school or its parent university.  | —   | —  |
| 6. The chief official of the medical school, who is ordinarily the Dean, SHOULD have ready access to the University President and such other University officials as are pertinent to the responsibilities of his office.                                      | —   | —  |
| 7. He SHOULD have the assistance of a capable business officer and such associate or assistant deans as may be necessary for such areas as student affairs, academic affairs, graduate education, continuing education, hospital matters and research affairs. | —   | —  |
| 8. The medical school SHOULD be organized so as to facilitate its ability to accomplish its objectives.  | —   | —  |
| 9. Names and functions of the committees established SHOULD be subject to local determination and needs.   | —   | —  |
| 10. Consideration of student representation on all committees IS both DESIRABLE and USEFUL.  | —   | —  |
| 11. The manner in which the institution is organized, including the responsibilities and privileges of administrative officers, faculty and students, SHOULD be clearly set out in either medical school or university bylaws.                                 | —   | —  |

FACULTY

- |  |   |   |
|--|---|---|
| 1. The faculty MUST consist of a sufficient number of identifiable representatives from the biological, behavioral and clinical sciences to implement the objectives that each medical school adopts for itself.                     | — | — |
| 2. ..the faculty SHOULD have professional competence as well as an interest in research and teaching in the fields in which instruction is to be provided.   | — | — |
| 3. Inasmuch as individual faculty members will vary in the degree of competence and interest they bring to the primary functions of the medical school, assignment of responsibility SHOULD be made with regard to these variations. | — | — |
| 4. The advantage to the student of instruction by such physicians (who are practicing in the community), as well as by those in full-time academic service, SHOULD be kept in mind.  | — | — |

Faculty (continued)

- |   | Yes | No  |
|---|-----|-----|
| 5. Nominations for faculty appointment ORDINARILY involve participation of both the faculty and the Dean, the role of each customarily varying somewhat with the rank of the appointee and the degree to which administrative responsibilities may be involved. | ___ | ___ |
| 6. Reasonable security and possibility for advancement in salary and rank SHOULD be provided (to the faculty).  | ___ | ___ |
| 7. A small committee of the faculty SHOULD work with the Dean in setting medical school policy.   | ___ | ___ |
| 8. (The committee) MAY be organized in any way that would bring reasonable and appropriate faculty and student influence into the governance of the school.   | ___ | ___ |
| 9. The faculty SHOULD meet often enough to provide an opportunity for all to discuss, establish, or otherwise become acquainted with medical school policies and practices.   | ___ | ___ |

STUDENTS

- |  |     |     |
|--|-----|-----|
| 1. The number of students that can be supported by the education program of the medical school and its resources, as well as the determination of the qualifications that a student should have to study medicine, ARE proper responsibilities of the institution.           | ___ | ___ |
| 2. ...it is DESIRABLE for the student body to reflect a wide spectrum of social and economic backgrounds.  | ___ | ___ |
| 3. Decisions regarding admission to medical school SHOULD be based not only on satisfactory prior accomplishments but also on such factors as personal and emotional characteristics, motivation, industry, resourcefulness, and personal health.                            | ___ | ___ |
| 4. Information about these factors CAN BE developed through personal interviews, college records of academic and non-academic activities, admission tests and letters of recommendation.   | ___ | ___ |
| 5. There SHOULD be no discrimination on the basis of sex, creed, race, or national origin.   | ___ | ___ |
| 6. ORDINARILY, at least three years of undergraduate education are required for entrance into medical school although a number of medical schools have developed programs in which the time spent in college prior to entering medical school has been reduced even further. | ___ | ___ |
| 7. The medical school SHOULD restrict its specified premedical course requirements to courses that are considered essential to enable the student to cope with the medical school curriculum.  | ___ | ___ |

Students (continued)

- |   | Yes | No |
|---|-----|----|
| 8. A student preparing for the study of medicine SHOULD have the opportunity to acquire either a broad, liberal education, or if he chooses, study a specific field in depth, according to his personal interest and ability. | —   | —  |
| 9. Advanced standing MAY be granted to students for work done prior to admission.   | —   | —  |
| 10. REQUIRE that transfers between medical school be individually considered so that both school and student will be assured that the course previously pursued by the student is compatible with the program he will enter.  | —   | —  |
| 11. There SHOULD be a system for keeping student records that summarizes admissions, credentials, grades, and other records for performance in medical school.  | —   | —  |
| 12. These records SHOULD reflect accurately each student's work and qualifications by including a qualitative evaluation of each student by his instructors.  | —   | —  |
| 13. It IS very IMPORTANT that there be available an adequate system of student counselling.   | —   | —  |
| 14. Academic programs allowing students to progress at their own pace are DESIRABLE.  | —   | —  |
| 15. There SHOULD be a program for student health-care that provides for periodic medical examination and adequate clinical care for students.   | —   | —  |

FINANCES

- |  |   |   |
|--|---|---|
| 1. The school of medicine SHOULD seek its operating support from diverse sources.  | — | — |
| 2. The support SHOULD be sufficient for the school to conduct its programs in a satisfactory manner.                       | — | — |
| 3. (The support) SHOULD reflect, as accurately as possible, the educational, research, and service efforts of the faculty. | — | — |

FACILITIES

- |   |   |   |
|---|---|---|
| 1. A medical school SHOULD have, or enjoy the assured use of, buildings and equipment that are quantitatively and qualitatively adequate to provide an environment that will be conducive to maximum productivity of faculty and students in fulfilling the objectives of the school. | — | — |
| 2. Geographic proximity between the preclinical and clinical facilities is DESIRABLE, whenever possible.  | — | — |

Facilities (continued)

	Yes	No
3. The facilities SHOULD include		
faculty offices and research laboratories	___	___
student classrooms and laboratories	___	___
a hospital of sufficient capacity for the		
educational programs	___	___
ambulatory care facilities	___	___
a library	___	___
4. The relationship of the medical school to its		
primary or affiliated hospitals SHOULD be		
such that the medical school has the unquestioned		
right to appoint, as faculty, that portion of		
the hospital's attending staff that will		
participate in the school's teaching program	___	___
5. All affiliation agreements SHOULD define clearly		
the rights of both the medical school and the		
hospital in the appointment of the attending		
staff.	___	___
6. Hospitals with which the school's association		
is less intimate MAY be utilized in the		
teaching program in a subsidiary way but all		
arrangements should insure that instruction		
is conducted under the supervision of the		
medical school faculty.	___	___
7. A well maintained and catalogued library,		
sufficient in size and breadth to support		
the educational programs that are operated		
by the institution, IS ESSENTIAL to a medical		
school.	___	___
8. The library SHOULD receive the leading medical		
periodicals, the current numbers of which		
should be readily accessible.	___	___
9. The library or other learning resource SHOULD		
also be equipped to allow students to gain		
experience with newer methods of receiving		
information as well as with self-instructional		
devices.	___	___
10. A professional library staff SHOULD supervise		
the development and operation of the library	___	___

Standards

The recently published criteria for Recognition of Accrediting Agencies and Associations of the Office of Education, DHEW, include the following references to standards:

"149.2 Accrediting means the process whereby an agency or association grants public recognition to a school, institute, college, university or specialized program of study which meets certain established qualifications and educational standards, as determined through initial and periodic evaluation...

149.6 (b) Responsibility. Its (the agency) responsibility will be demonstrated by the way in which --

... (2) (ii) The agency or association publishes or otherwise makes publicly available:

(A) The Standards by which institutions or programs are evaluated.

... (5) It maintains a program of evaluation of its educational standards designed to assess their validity and reliability.

... (8) It accredits only those institutions or programs which meet its published standards and demonstrates that its standards, policies and procedures are fairly applied and that its evaluations are conducted and decisions rendered under conditions that assure an impartial and objective judgment."

## STANDARD ELEVEN\*

## Research

As long as colleges and universities have been established, members of their faculties have made significant contributions through the discovery of new knowledge. The zest for discovery of truths as well as for the communication of knowledge is an essential characteristic of an atmosphere conducive to the development of scholarship.

For adequate support of his individual research program, the teacher-investigator must frequently seek funds from outside sources. In recent years ever-increasing financial support for research has been made available through private and governmental agencies. Such contractual or sponsored research has become an integral part of the activities of colleges and universities today.

Policies relative to research should insure conformity of this activity to the stated purposes of the institution, provide an appropriate balance between research and instruction, and guarantee control of administration of the research by the institution. The investigator's freedom in research, including direction and communication of results, should be preserved.

In using funds from contracts, grants, and contributions in support of research, the institution should not become dependent upon that portion allowed for indirect or overhead cost in support of its regular operating budget.

## Illustrations and Interpretations

1. *Administration*

Although many advantages accrue to institutions from research support possibilities through private and governmental agencies, problems often arise through research contract and grant procedures and administration. As a means of dealing with these problems, the administration of research should provide for conformity of research activities to the stated purposes of the institution.

Responsibility for contractual research should be related to departmental administration. If departmental administration fails to provide leadership, lack of morale and lack of coordination of activities can result.

The institution should have a clear policy relative to the division of responsibility between research and other activities. Certainly each institution may set up its own policy,

\* The Southern Association of Colleges and Schools, Standards of the College Delegate Assembly, December 13, 1972, Atlanta, Georgia, Southern Association of Colleges and Schools, 1972, pp. 26-27.

but it seems essential that some policy be established and that all concerned conform to the stated policy.

The institution should develop definite policies relative to summer salaries paid from contract and grant funds, to salary supplements during the regular academic year, and to research consultative services undertaken by faculty members. These policies may well vary from institution to institution, but again a clearly understood policy is needed.

Administration of research contracts and grants should attempt to minimize the amount of time utilized by the teacher-investigator in seeking support for and in administering individual research contract and grant programs. Much time can be saved him if the administrative organization within the institution provides relief for as much responsibility as possible in administrative matters.

## 2. *Institutional Control*

In accepting funds from outside agencies, the institution must maintain control of its policies relative to research and instruction. Many agencies attach rather stringent regulations directing and limiting the character of research if they provide funds to support it. The rapid growth in acquisition of research grants from and contracts with outside agencies can endanger the institutional control of its activities unless this prerogative of the college or university is carefully guarded.

Continuity of support for general institutional research activities should not be endangered through the acquisition of research contracts and grants. Grants are given and contracts are made for limited lengths of time. When and if the institution becomes dependent, even partially, upon such funds for faculty salaries or graduate fellowships and assistantship stipends in support of graduate programs, termination of grants or contracts may mean the entire educational program, as well as the research activities, would be seriously jeopardized.

## 3. *Primacy of Teaching Obligations*

Discharging responsibility to granting agencies must not reduce teaching effectiveness on the part of the teacher-investigator. The faculty member receiving support from without the university for his research program naturally feels responsible to the granting agency to accomplish the research expected, but teaching obligations must not be neglected in order that this responsibility be discharged.

4. *Faculty Morale*

Care should be exercised that support from outside agencies in some areas within the college or university does not affect adversely morale in other areas through development of jealousies. If teaching loads are reduced so that obligations to outside agencies may be satisfied, resentment on the part of persons in other areas, or even in the same area, can be significant basis for low morale. The administrative officers of the institution should provide research support and time for those who are not in a position to seek grants.

5. *Expenditure of Research Funds*

An institution has the prerogative of developing its own policy of purchasing procedures and, in general, purchases with contract funds should conform to the established procedural policy. Most granting agencies state clearly that purchasing procedures using grant funds must conform to the institution's policies; however, it is not essential that policies governing expenditures of research funds be the same as those governing expenditures of general funds.

6. *Freedom of Investigation*

The elements inherent in undertaking "classified" research should not tend to destroy the principles of freedom of investigation and of reporting results. This freedom has always been a sacred prerogative of faculties of educational institutions of higher learning, whether privately or publicly supported.

AMA REPRESENTATIVES FOR SURVEY VISITS

GENERAL FIELD

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinic
Allan Bass		1	1			X	
Steven Beering	1			X			
E. N. Boettcher		1			X		
Warren Bostick	1	1	1	X			
James Campbell	1			X			
Bland Cannon	2	2	1				X
H. Meade Cavert	1			X			
Earle Chapman		1	1				X
Jack W. Cole		1					X
F. Coleman			1				X
J. Conger			1	X			
Patrick J.V. Corcoran	1	1					X
Perry Culver		1	1		X		
James Dennis		1	1				X
R. C. Derbyshire	1	1	1				
John Dixon	1	1		X			X
F. Eagle		1					X
Richard Ebert	1	1					X
Harlan English			1				X
Russell Fisher	1						X
Ed Flink			1				X
Eva Fox	1	1					
John G. Freymann	1				X		
Allwyn Gatlin	1					X	
Sam Harbison			1				X
James Haviland	1	1	1				X
William Holden	1	1	1				X
Charles Hudson	1	1					X
John E. Ives		1					
William Kellow	1		1	X			
Gerald A. Kerrigan	1			X			
Charles Kidd			1	X			
William Knisely	1		1			X	

AMA REPRESENTATIVES FOR SURVEY VISITS

GENERAL FIELD

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinician
Francis Land	1	1	1				X
George Leroy	1			X			X
Morton Levitt		1					X
William Maloney		1		X			X
Richard Manegold	1	1				X	
Horace Marvin	1	1	1	X			
R. Magraw			1				X
William Meacham	1			X			X
Thomas Mou	1						X
Merle Mussleman	1					X	
H. Nicholson		1					X
John Nunemaker	1	1					X
Stanley Olson			1	X			X
Claude Organ	1						X
F. Paustian		1					
Warren Pearse			1	X			
Edward Pelegrino	1	1	1	X			
Ken Penrod	1	1		X			
Chase Peterson	1			X			
Gilles Pigeon		1					X
Bernard Pisani	1	1	1				
Warren Point	1			X			X
Bryce Robinson	1	2					X
W. Rial			1				X
Edward Rosenow	1	1	1				
William Ruhe		1	1	X			
John Sheehan			1	X			
T. Sherrod		1				X	
F. Simeone		1					X
William A. Sodeman	1	1	1	X			
John Stapleton			1	X			
Robert Stone			1	X			
M. Watts		1		X			

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AMA REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinician
William Wartman	1					X	
Joseph White	1	1	1	X			
H. Wiggers			1	X			
J. Jerome Wildgen	1						X
William Willard	1	1	1	X			
David Wilson	1	1	1		X		
Michael Wilson			1			X	X
Vernon Wilson		1		X			
SECRETARIES							
David Babbott			1				
Warren Ball	1						
John Ballin	1	1					
Barclay			1				
Anne Crowley	1						
Richard Egan	6	4	2				
J. Fauser		1					
Leonard Fenninger	1						
Asher Finkel	1	1	1				
H. Glass	1		1				
Norman Hoover			1				
Rut Howard			1				
Ralph Kuhii			1				
D. Lehmkuhl		1					
Glen R. Leymaster	3	2	1				
Clark Mangum	1						
H. Nicholson			4				
Edward Petersen	4	4					
Philip White		1	1				
T. Zimmerman			1				

AAMC REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinician
George Aagard			1	X			X
Eobby R. Alford	1						
J. E. Anderson	1					X	
Len H. Andrus	1						X
Sam Asper			1				X
Truman Blocker	2		1	X			
Daniel Bloomfield	1			X			
Edward Bresnick	1					X	
John Brobeck	1					X	
Robert Bucher	1			X			
Ralph Cazort	1	1		X			
G. Cartmill			1		X		
Carleton Chapman			1	X			
John Chapman	1	1	1	X			
A. L. Chute		1					
Samuel L. Clarke, Jr.	1		2			X	
Jack M. Colwill	1						X
William G. Cooper		1					
Kenneth Crispell	3	2	1	X			
Joyce Davis	1	1				X	
John Dietrick	1			X			
William Drucker	1	1		X			
Dick Ebert			1				X
James Eckenhoff		1	1	X			
L. Elam		1					
Paul Elliott	1			X			
R. Estabrook		1				X	
J. Feffer		1		X			
Pat Fitzgerald			1				
Christopher Fordham	1	1		X			
Shervert Frazier	1	1					X
Neal Gault	1	1		X			

AAMC REPRESENTATIVES FOR SURVEY VISITS

GENERAL FIELD

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinician
Clifford Grulee	1	1	1	X			
T. Stewart Hamilton	1		1		X		
R. Hardin		1			X		
R. Heyssel		1	1				X
Doris Howell						X	
Clyde G. Huggins	1		1	X			
Andrew Hunt	1	1	1	X			
G. Irwin						X	
Paul C. Johnson	1		1	X			
Thomas D. Kinney	1	1	1			X	
Ernst Knobil	1	1	1			X	
Jack Kostyo			1				X
Lucian Leape						X	
Morton Levitt		1	1				
Robert A. Liebelt	1	1		X			
Marion Mann	1			X			
Robert Q. Marston							
R. G. McAuley		1					
Frank McKee		1		X			
Manson Meads			1				X
Max Michael		1				X	
Howard Morgan	1	1					X
R. Hugh Morgan			1				
J. Myers		1		X			
Stanley Olson	1			X			
Robert Page	1			X			
Carter Pannill	1	1		X			
Emanuel Papper			1	X			
John Parks						X	
Lytle Peterson	1						

AAMC REPRESENTATIVES FOR SURVEY VISITS

GENERAL FIELD

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinician
Walter Rice	1		1	X		X	
William Rieke			1			X	
G. Gordon Robertson	1	1				X	
R. Saunders		1				X	
Roy Schwarz	1	1		X			
D. Scarpelli		1		X			
J. R. Schofield					X		
Stuart Sessoms	1			X			
W. Shorey			1			X	
Parker Small	1			X			
Donn Smith	1			X			
Cheves Smythe	1	1	1	X			
Robert D. Sparks		1		X			
Charles Sprague	1	1			X		
John Stagle			1				
Robert Stone		1		X			
M. Suter			1	X			
Isaac Taylor	1					X	
Dan Tosteson			1	X			
C. John Tupper	1	1	1				X
Carlos Valibona	1						X
Douglas Walker	1	1					X
William B. Weil, Jr.	1		1			X	
Alfred Wilhelmi			1				
George Wolf			1	X			
SECRETARIES							
David Babbott		1					
Michael Ball	1						
Thompson Bowles		1	1				
William Cooper	1						
James Erdmann	1	1					
Doris Howell	2						

AAMC REPRESENTATIVES FOR SURVEY VISITS'

GENERAL FIELD

	<u>1973-1974</u>	<u>1972-1973</u>	<u>1971-1972</u>	<u>Dean/ Administrator</u>	<u>Hospital Administrator</u>	<u>Basic Scientist</u>	<u>Clinician</u>
SECRETARIES (cont'd)							
Roy Jarecky	1	1	1				
Davis Johnson	1	1	1				
Richard Knapp	1	1	2				
Carter Pannill		1					
Walter Rice		1	1				
J. R. Schofield	3	4	3				
Frank Stritter	1		1				
Emanuel Suter	2	1					
August Swanson		1	1				
Marjorie Wilson	1	2	1				

Schedule for Survey Visit, June 12 - 15Monday, June 12

~~9:00 a.m.~~ Dr. J. Robert Buchanan, Dean and Dr. Fletcher H. McDowell, Associate Dean

9:25 Meet other Associate Deans

Team ATeam B

9:45 Dr. Fritz F. Fuchs, Professor of Obs-Gyn Dr. Fred Plum, Professor of Neurology

10:45 Mr. M. James Peters, Fiscal Officer

11:30 Dr. Charles A. Santos-Buch, Associate Dean - Student Affairs

12:15 p.m. Lunch with students

1:15 Dr. Arthur H. Hayes, Jr., Associate Dean - Academic Programs

2:00 Dr. Thomas H. Meikle, Jr., Associate Dean (Basic Sciences), Chairman, Admissions and Dean, Graduate School of Medical Sciences

2:45 Members of Basic and Clinical Science Faculty Councils

Team ATeam B

3:30 Dr. James L. Curtis, Associate Dean - Minority Groups

Mr. Erich Meyerhoff, Director of the Library

Tuesday, June 13

9:00 a.m. Dr. J. Robert Buchanan, Dean

9:30 Dr. E. Hugh Luckey, President, The New York Hospital-Cornell Medical Center

Team ATeam B

10:30 Dr. John A. Evans, Professor of Radiology Dr. Paul A. Ebert, Professor of Surgery

11:30 Dr. John T. Ellis, Professor of Pathology Dr. William T. Lhamon, Professor of Psychiatry

12:30 p.m. Lunch with house staff (and young faculty)

Team A

Team B

1:30 Dr. W. P. Laird Myers, Chief of  
Medicine, Memorial Hospital

Dr. Alton Meister, Professor of Biochemistry

2:30 Dr. Alexander G. Bearn, Professor of  
Medicine

Dr. Michael A. Alderman, Assistant Professor  
of Public Health (substituting for  
Dr. Walsh McDermott, Professor)

3:30 Dr. Robert F. Pitts, Professor of  
Physiology

Dr. George G. Reader, Professor of Public  
Health-elect

Wednesday, June 14

9:00 a.m. Dr. Roy C. Swan, Professor of Anatomy

Dr. William F. Scherer, Professor of  
Microbiology

10:00 Dr. David D. Thompson, Director, The New York Hospital

Team A

Team B

11:00 Dr. Wallace W. McCrory, Professor of  
Pediatrics

Dr. Walter F. Riker, Professor of  
Pharmacology

12:00 Noon Lunch Faculty - younger group

1:00 p.m. Dr. Bruce H. Ewald, Director, Laboratory Animal Medicine

2:00 Dr. Charles L. Christian, Chief of Medicine, Hospital for Special Surgery

3:30 President

Thursday, June 15

9:00 a.m. - Dr. Buchanan

10:30 a.m. - President or Provost

FROM: Glen R. Leymaster, M.D.

RE: Survey of

3. Kenneth E. Penrod, Ph.D. (Chairman); Robert G. Page, M.D.  
Douglas Waugh, M.D.; Michael F. Ball, M.D.; James B. Erdmann, Ph.D. (Secretary)

RECOMMENDATIONS: That \_\_\_\_\_ be granted full accreditation for seven years as of the final date of this survey,

The survey team also recommends to the Executive Council of the Association of American Medical Colleges that \_\_\_\_\_ be granted full Institutional Membership.

This recommendation for approval should be interpreted to apply to the currently requested increases of class size for the first year from 93 to 108 and for the third year from 32 to 56. Approval for these class sizes is contingent upon presenting satisfactory evidence to the LCME that:

(a) a mechanism is established for orderly planning and development of expansion activities.

(b) additional clinical faculty are acquired in areas of need as identified in the report.

The team does not endorse expansion beyond these levels for either of the above classes without the specific review of the LCME.

The Dean should submit a letter to the LCME Secretary early in 1975 detailing progress in achieving these contingencies.

<u>Name</u>	<u>Accept</u>	<u>Approve</u>	<u>Comment</u>
<u>COUNCIL ON MEDICAL EDUCATION, AMA</u>			
Bostick	X		Approval for a term limited to 5 years. (7 years is too long). They have too much to do. I believe their class (freshman) increase should be delayed at least 1 year.
Burgher	X	X	
Cannon	X	X	Approval with contingencies.
Fisher	X	X	Concur with limitations on increasing student body.
Haviland	X	X	The 7 year approval hedged by the tight restrictions would appear to call for more progress reports than the single item for 1975.
Pisani	X	X	Recommendations and suggestions regarding clinical department are very important and call for early implementation.
Sodeman	X		Approval for a term limited to 4 years. The current status of clinical facilities, lack of 3 permanent departmental chairmen, lack of development of institutional and departmental objectives, and lack of final basic science coordination, I believe warrant less than full approval.
White	X		Approval for a term limited to 3 years. I cannot vote approval for seven years for a school unable to accommodate its full entering class at the clinical level. This needs discussion.

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<u>Name</u>	<u>Accept</u>	<u>Approve</u>	<u>Comment</u>
Wildgen	X		Pathology appears weak. Autopsy Rate & Volume not recorded. Excellent approach in Family Medicine but no mention of student contact before 4th year. I suggest earlier involvement.
V. Wilson	X	X	In 2 1/2 years a great deal has happened. The areas of criticism should be remedied if the present trend is maintained.
<u>PUBLIC MEMBERS, LCME</u>			
Inskip	X	X	Approval for 7 years, with stipulations.
Stark	X	X	Approval for 7 years.
<u>FEDERAL REPRESENTATIVE, LCME</u>			
Stone	X	X	Approval for 7 years
<u>ASSOCIATION OF AMERICAN MEDICAL COLLEGES</u>			
Buchanan	X	X	
Cazort	X	X	
Clarke-Pearson	X	X	Excellent Report.
Cole	X	X	
Crispell	X	X	Amazing improvement, a long way to go.
Cronkhite	X	X	
Derzon	X	X	Approval as noted.
Estabrook	X	X	Approval only as long as class size is 108. I strongly vote that class size should not increase above 108 per entering class until another survey is completed and adequate facilities are demonstrated.
Grulee	X	X	
Hamilton		X	Despite (or because of) the length of this report, I had difficulty getting a mental picture of the school. I missed specific comments such as ratios of applicants to places, average scores, etc. Among the problems (for me) was the statement that the school needs a new hospital without comment as to whether the area needs the beds, how it will be constructed or financed. This is 1974, not 1964.
Kinney	X	X	The matter of class size should be carefully considered at meeting of LCME
Knobil			Report Not Acceptable - Approval for a term limited to 5 years. Contents of report are O.K., but as an official document of AMA and AAMC it is excessively sloppy in appearance and replete with spelling and typographical errors. Such shoddiness should be unacceptable. Seven years is a lot too long a period of accreditation for this institution.
Krevans	X		Approval for a term limited to 4 years. It seems to me that there are enough critical unresolved issues that another look is justified before 7 years.
Lewine	X	X	Findings seem to indicate borderline decision between full accreditation and more limited approval.

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<u>Name</u>	<u>Accept</u>	<u>Approve</u>	<u>Comment</u>
Mellinkoff	X	X	Caveats Noted.
Papper	X	X	There are some serious problem areas at ; especially in the area of clinical faculty recruitment and expansion of some teaching facilities. However, one must be impressed by the Visiting Team's impression of the progress made since the last site visit. Certainly the credits far outweigh the deficits and the School deserves full recognition with the stipulated qualifications.
Petersdorf	X	X	
Tosteson	X	X	
Tupper	X		Approval for a term limited to 3 years. In spite of commendable progress, the continuing problems are so real that more than a 3 year approval seems incomprehensible.
Van Citters	X		Approval for a term limited to 2 years. The recommendations for 7 years accreditation & full institutional membership are not consistent with citation of 16 "Serious Weaknesses"-- "require immediate action" (See Pages 66-69) I think this operation has a Hell of a way to go before it can be looked on as a first line going concern.
<u>ADVISORY COMMITTEE, AMA</u>			
Brown	X	X	Should be definite that approval extends only to entering class size of 108.
Bucher	X	X	
DeLoysshire	X		In view of the many deficiencies I think the decision of the team was most generous.
Fox		X	
Magraw	X	X	Approval for regular term with conditions-- The issues associated with the imposition of foreign trained students onto a new curriculum, and newly formed faculty and the apparently successful resolution of problems and successful completion of studies merit a survey report all to themselves. Where is the money for a tertiary care hospital going to come from? What is the population the hospital will serve?
O'Neal	X	X	Excellent report - good details for insight.
<u>ADDENDUM</u>			
Culver	X	X	Many helpful recommendations in this report made by the Survey Team. I am increasingly of the persuasion that a Flexnerian basic science curriculum along departmental lines & with repetition is the preferable approach to medical education.

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
September, 1973 - June, 1974				
Albany Medical College	Continued full approval for seven years as of 9/23/73 and continued membership in the AAMC.	YES 39 NO 0	YES 39 NO 0	Same as team recommendation
University of Texas Medical School at Houston	Full accreditation for two years as of 9/27/73 and membership in the AAMC. Recommended entering class not be increased above present 48 until present building program completed.	YES 41 NO 0	YES 40 + 1 ? NO 0	Same as team recommendation
University of Chicago Pritzker School of Medicine	Continued full approval for seven years as of 10/3/73 and continued membership in the AAMC.	YES 39 NO 0	YES 39 NO 0	Same as team recommendation
Mayo Medical School	Continued provisional approval pending resurvey before graduation of first class. Number of entering students should continue to be 40. Facilities are more than adequate for the admission of up to ten more students into the second year, a total of 50 students, through the prospective contract with North Dakota, or by other means.	YES 37 NO 0	YES 37 NO 0	Same as team recommendation
University of North Dakota School of Medicine	Continued full approval as a School of Basic Medical Science and continued membership in the AAMC. Provisional approval as an M.D. degree-granting School which will implement a third-year curriculum for 40 students by contract in 1974 and a fourth year curriculum for 40 students in 1975.	YES 36 NO 1	YES 27 NO 9	Same as team recommendation with additional statement: SINCE THE CURRENT SITUATION IS DIRECTED TO THE DEVELOPMENT OF AN M.D. DEGREE GRANTING INSTITUTION, THE SCHOOL WILL BE SURVEYED IN APPROXIMATELY TWO YEARS DURING THE ACADEMIC 1975-76 YEAR IF DEVELOPMENT PROCEEDS AS PLANNED.

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE, RECOMMENDATION	FINAL LCME ACTION
The University of Nebraska	Full accreditation for a period of two years with a progress report submitted in one year to LCME, and continued membership in the AAMC.	YES 31 NO 1	YES 27 NO 5	Same as team recommendation with additional statement: PROGRESS REPORT IS REQUESTED BY NOVEMBER 1, 1974, WHICH RESPONDS TO THE NUMEROUS CONCERNS EXPRESSED BY THE TEAM UNDER THE SUMMARY AND CONCLUSIONS OF THE REPORT.
Hahnemann Medical College and Hos- pital	Full accreditation for a period of one year and continued membership in the AAMC. Postponement of authorization for increasing by 50 students the size of the entering class (entering class in 1973 was 154).	YES 38 NO 1	YES 33 6	Same as team recommendation
College of Medi- cine & Dentistry of New Jersey -- Rutgers Medical School	Full accreditation for a period of seven years and continued membership in the AAMC. Approval applies to currently requested increases of class size for the first year from 93 to 108 and for the third year from 32 to 56. Approval for these class sizes is contingent upon presenting satisfactory evidence to LCME that: a) a mechanism is established for orderly planning and development of expansion activities; and b) additional clinical faculty are acquired in areas of need as identified in the report. The Dean should submit a letter to the LCME Secretary early in 1975 detailing progress in achieving these contingencies.	YES 29 NO 3	YES 26 6	FULL ACCREDITATION FOR A PERIOD OF FOUR YEARS WITH PROGRESS REPORT DUE NO LATER THAN OCTOBER 1, 1974 PROVIDING DETAILS OF ADDITIONAL FACULTY RESOURCES PROVIDED TO MEET THE OBLIGATIONS TO THE INCREASED NUMBER OF STUDENTS. Otherwise same as team recommen- dation.
University of Massachusetts	Full accreditation for a period of two years with membership in the AAMC. Progress report in one year concerning staffing of the Departments of Pharmacology, Obstetrics and Gynecology, Pediatrics and Psychiatry. Although the class size planned, namesly 64 in 1974 and 100 in 1975, is appropriate, it is suggested that the faculty give consideration to the admission of 100 students in 1974.	YES 35 NO 1	YES 34 NO 2	Same as team recommendation

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION	3
Texas Tech University School of Medicine	Full accreditation for a period of one year and full membership in the AAMC. Recommended that the entering class not be increased beyond 40 students until the present building program is completed, an event now expected to occur in mid-1975.	YES 31 NO 3	YES 29 NO 5	Same as team recommendation	
Medical University of South Carolina	Full accreditation for a period of seven years and continued membership in the AAMC.	YES 36 NO 0	YES 31 NO 5	Full accreditation for a period of four years with a Progress Report due by January 1, 1976 concerning finances. Full membership in the AAMC.	
University of Missouri--Kansas City School of Medicine	1. Full accreditation for a period of two years. Because of the unusual difficulties involved in understanding this innovative and complex program, the next survey team should include 1 or two members of an earlier team. 2. Approval for enrollment of 72 students in the third year for 1974-75. 3. Approval for enrollment of 80 first year students in 1974 and 90 in 1975. This plan is in accord with the School's own projected rate of growth. 4. Recommends admission of up to 12 additional students (in advance standing) into years 3, 4, or 5 in accord with the conditions outlined by Dr. Dimond, which includes the intent to offer these opportunities to nurses, oral surgeons, and Ph.D.'s in the life sciences, with no student to be awarded the M.D. degree after less than 24 mos. in residence in the Medical School. 5. Full membership in the AAMC.	YES 22 NO 8	#1 #2 #3 #4 #5 YES 27 27 22 9 27 NO 4 4 9 22 4	1. Full accreditation for two years. 2. Enrollment of 72 year 3 students in 1974-75. 3. Enrollment of 72 year 1 students in 1974-75 and 72 students in 1975-76. 4. Approval of admission of up to three additional students in to years 3, 4, & 5 in 1974. Total number of students admitted to advanced standing should not total more than ten by the 1975-76 year.	

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
University of Southern Cali- fornia	Full accreditation for a period of seven years and continued membership in the AAMC.			Same as team recommendation
UCLA School of Medicine	Full accreditation for a period of seven years and continued membership in the AAMC.	YES 36 NO 1	YES 36 NO 1	Same as team recommendation
Boston University School of Medi- cine	Full accreditation for a period of seven years and continued membership in the AAMC. Entering class of up to 133 students in 1975-76.	YES 21 NO 0	YES 20 NO 1	Same as team recommendation
SUNY-Stony Brook Medical School	Full approval for a period of two years and the number of first-year students be limited to 48 for the year 1974-75, and to 60 for the year 1975-76. Membership in the AAMC.	YES 30 NO 2	YES 29 NO 3	Same as team recommendation
Medical College of Ohio at Toledo	Full approval for a period of three years and continued membership in the AAMC. Progress report request early in 1976 describing progress in the development of the Basic Science Gradu- ate Program, the Clinical Graduate Program, and the faculty of the clini- cal departments in the affiliated hospitals. Faculty and facilities are considered adequate for the entering classes namely 80 in 1974 and 96 in 1975. Should an entering class larger than 100 for 1976 be contemplated, the 1976 report should be expanded to include progress in the completion of basic science facilities and staffing of basic science departments.	YES 18 NO 1	YES 19 NO 0	Same as team recommendation

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
University of Arkansas School of Medicine	Full accreditation for a period of seven years and continued membership in the AAMC.	YES 18 NO 1	YES 18 NO 1	Same as team recommendation
University of Hawaii School of Medicine	Continued provisional accreditation for an entering class of 66 students and continued membership in the AAMC.	YES 19 NO 0	YES 17 NO 2	Same as team recommendation
Texas A & M University/Baylor College of Medicine	Recommends against issuing letter of reasonable assurance and against provisional accreditation at this time.	YES 19 NO	YES NO	Same as team recommendation
Southern Illinois University School of Medicine	Continued Provisional Accreditation and continued provisional membership in the AAMC. No further acceptances to the first-year class entering June 1974 shall be offered after March 12, 1974; Acceptances offered prior to March 12 for places in the June 1974 places shall be honored; If students who have been previously accepted places in the class withdraw, they shall not be replaced unless the number of students accepted for admission shall be 48 or less; in this circumstance additional acceptances may be offered in order to enroll 48 students; No students shall be accepted for advanced standing after March 12, 1974; School to be resurveyed in January or early February, 1975. Until completion of this survey and action by the LCME, acceptances for the entering class in June 1975 shall be limited to 48 students.	YES 24 NO 4	YES 28 NO 0	Same as team recommendation with the number of students being 60 instead of 48 - this was based on the fact that the LCME had earlier on accepted the school's planned expansion which included 60 students for 1974-75. 48 students were specifically indicated for 1973-74
University of Connecticut School of Medicine	Full accreditation for a period of four years with continued membership in the AAMC. Progress report by January 1, 1976 with detailed information on the specified items.	YES 34 NO 0	YES 30 NO 4	Same as team recommendation

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION	6
University of Nevada School of Medicine	Full accreditation for a period of two years and continued membership in the AAMC. Entering class should not be increased beyond the present size of 48, and a Letter of Reasonable Assurance for expansion beyond this size is not issued. Progress Report in June, 1975 concerning the state budget for the years 1975-76.			Same as team recommendation	
Loma Linda University School of Medicine	Continued full accreditation for a period of seven years and continued membership in the AAMC. Progress Report due as of October 1, 1974 and a limited resurvey during the 1974-75 academic year.	YES 35 NO 1	YES 28 NO 8	Action deferred to next LCME meeting.	



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

September 13, 1974

WASHINGTON: 202: 466-5175

MEMORANDUM

TO: AAMC Executive Council Members and Invited Guests  
FROM: John A. D. Cooper, M.D.  
SUBJECT: AMA Guidelines for Housestaff Contracts

Enclosed for your review are revised "AMA Guidelines for Housestaff Contracts." The AAMC has been asked by Dr. James H. Sammons, AMA Vice President Designate, to comment on these Guidelines at a Board of Trustees meeting in late October. As you probably know, the AMA House of Delegates deferred action on these Guidelines until their December meeting.

Please be prepared to comment on these Guidelines at the Executive Council meeting on September 20.

Enclosure

cc: Executive Staff; Dr. Ball; Dr. Pointer

SEP 31 1974

AMERICAN MEDICAL ASSOCIATION  
GUIDELINES FOR HOUSESTAFF CONTRACTS

1     I. Introduction

2  
3         Training programs have been central to the post-graduate educational  
4 process which has produced a high level of medical competency in the United  
5 States. This Association has long recognized that the integrity of those programs  
6 is a primary objective. It is, therefore, incumbent upon housestaff officers and  
7 the institutions at which they are being trained to be aware of the parameters and  
8 responsibilities which are applicable to their training program. Without such  
9 awareness unreasonable expectancies may arise to threaten the harmony between hos-  
10 pital and housestaff in the performance of their joint mission. The following outline,  
11 based upon substantial experience, is intended to provide guidance to those en-  
12 gaged in developing housestaff contracts.

13  
14         It should, of course, be emphasized that no fixed formula is intended by  
15 these guidelines. It is understood that guidelines which seek to cover public,  
16 voluntary, and proprietary hospitals necessarily entail so many variables from  
17 training institution to training institution that no single form of contract  
18 would be helpful. The American Medical Association has therefore developed a  
19 set of guidelines for the more important substantive provisions of the housestaff  
20 contract.

21  
22         The subjects here included are not intended as the only subjects of im-  
23 portance for a contract or appropriate for every contract. Moreover, the de-  
24 finition of the respective responsibilities, rights and obligations of the  
25 parties involved can assume various forms: uniform individual contracts, group  
26 contracts, or as part of the rules of government of the institution. In each  
27 instance, it will be necessary for the housestaff association to evaluate its  
28 needs and the ability of the institution to fulfill them and then establish  
29 priorities and bargain accordingly with the institution.

30  
31     II. Proposed Terms and Conditions

32  
33     A. Parties to the Agreement

34  
35         The representative status of the housestaff association should be expressly  
36 accepted and recognized in the contract.

37  
38         The contract may be between a housestaff association with members in several  
39 institutions, and a group of related institutions (such as all city hospitals in  
40 a certain city), or it may be between a housestaff association and single insti-  
41 tution.

1           Position, salary and all other benefits should remain in effect without  
2 regard to rotational assignments, even if they are away from the parent  
3 institution.  
4

5           The agreement should provide coverage for all those performing the  
6 duties of interns, residents and fellows. Particular care should be taken  
7 to protect against the practice of unpaid "volunteers" performing such duties.  
8

9  
10           Individual housestaff officer contracts should be required to be con-  
11 sistent with the principal contract, if any.  
12

13           Adequate prior notification of the institution's intention not to renew  
14 an individual's contract should be required so that the housestaff officer will  
15 have sufficient time to obtain another appointment.  
16

17       B.   Obligation of Housestaff  
18

19           Housestaff members should agree to fulfill the educational requirements  
20 of the residency program, and to use their efforts to provide safe and effec-  
21 tive patient care as assigned or required under the circumstances as delineated  
22 in The Essentials of Approved Residencies and approved standards of the AMA  
23 Council on Medical Education.  
24

25           Housestaff members should comply with the laws, regulations and policies  
26 to which the institution is subject.  
27

28       C.   Obligation of the Institution  
29

30           The Institution should agree to:

- 31
- 32       . provide a training program which meets the standards of the AMA Essentials  
33       of Approved Residencies;
  - 34       . continuously maintain its staff and its facilities in compliance with  
35       all of the standards of the Essentials of Approved Residencies;
  - 36       . proscribe increasing the pyramidal nature of the training program during  
37       the tenure of persons already in or accepted to that program.  
38  
39

D. Salary of Housestaff

1 The salary to be paid to each level of housestaff, and the day of the  
2 payment should be specified. If there are to be progressive increases, the  
3 basis for the increase should be specified, together with the time when such  
4 increases are to take effect.  
5

6 In determining the salary level of a housestaff officer, credit should  
7 be provided for prior training experience where a house officer has shifted  
8 from one program or institution to another.  
9

10 A specific salary differential should be provided for chief residents  
11 or their equivalent.  
12

13 Other specific salary differentials may be provided where appropriate  
14 in particular services.  
15

E. Hours of Work

16  
17  
18 There should be a recognition of the fact that long duty hours extending  
19 over an unreasonably long period of time or onerous on-call schedules are not  
20 consistent with the primary objective of education or the efficient delivery of  
21 optimum patient care. The institution should commit itself to fair scheduling  
22 of duty time for all housestaff members, as well as the provision of adequate  
23 and defined off-duty hours.  
24

F. Off-Duty Activities

25  
26  
27 The contract could provide that a housestaff officer is free to use his  
28 off-duty hours as he sees fit, including engaging in outside employment so long  
29 as such activity does not interfere with obligations of the housestaff member  
30 to the institution or to the effectiveness of the educational program he is  
31 pursuing.  
32

G. Vacations and Leave

33  
34  
35 The amount of vacation, sick leave and educational leave to which each  
36 housestaff member is entitled should be specified.  
37

38 Vacation should be expressed in terms of customary working days as  
39 defined by the institution.

1 If vacations may be taken only at certain times of the year, this  
2 should be expressed. Any requirements for scheduling vacation time also  
3 should be stated.  
4

5 Leave provision may also cover maternity, paternity, bereavement,  
6 military duty examinations, preparations therefore, and educational con-  
7 ferences. Reimbursements for tuition and expenses incurred at educational  
8 conferences should be considered.  
9

10 The agreement should set forth any progressive increases in the amount  
11 of time allowed for vacations, sick leave and educational leave.  
12

13 Educational leave should not be deducted from vacation time.  
14

#### 15 H. Insurance Benefits 16

17 Insurance benefits should be set forth with particularity and should be  
18 tailored to the specific needs of housestaff officers.  
19

20 Some of the more common insurance benefit provisions are (1) hospitali-  
21 zation and basic medical coverage for the housestaff member, spouse and minor  
22 children; (2) major medical coverage for housestaff members and family; and  
23 (3) group life insurance, and dismemberment and disability insurance for the  
24 housestaff member only.  
25

26 It also should be specified whether the institution will pay the full  
27 amount of premiums or only a portion of the premiums, the balance to be paid  
28 by the housestaff member. Co-paid benefits should be established, separately  
29 from other hospital employee benefits, as a means of maximizing benefits.  
30

31 In some instances, free care for housestaff officers and their families  
32 at the training institutions may be provided.  
33

34 In lieu of insurance benefits, the contract may provide for fixed annual  
35 payments to the housestaff association for each housestaff officer so that the  
36 housestaff association may determine and provide for insurance or other benefits  
37 for housestaff officers.  
38

#### 39 I. Professional Liability Insurance 40

41 The contract should specify the amount of professional liability insurance  
42 which the institution will provide for each housestaff member together with the

1 limits of liability applicable to such coverage.  
2

3 It might also be appropriate to provide in the contract that the  
4 housestaff members and the institution will fully cooperate with the  
5 insurance company in the handling of any professional liability claim.  
6

7 J. Committee Participation  
8

9 Insofar as possible, the institution should agree to provide for  
10 appropriate participation by housestaff members on the various committees  
11 within the institution. This participation should be on committees concern-  
12 ing institutional, professional and administrative matters. Members should  
13 have full voting rights. Housestaff members should be selected by the  
14 housestaff association members themselves.  
15

16 K. Grievance Procedures  
17

18 The contract should provide a grievance procedure. That procedure  
19 typically involves the following:  
20

- 21 1 - a definition of the term "grievance" (e.g., any dispute or con-  
22 troversy about the interpretation or application of the contract,  
23 any rule or regulation, or any policy or practice);  
24
- 25 2 - timing and sequence of the grievance steps (e.g., referral to  
26 the chief of service, then to the medical board or administrator  
27 as a review body);  
28
- 29 3 - a right to legal and other representation at each step for the  
30 housestaff officer;  
31
- 32 4 - the right of a housestaff association independently to initiate  
33 and process a legitimate grievance;  
34
- 35 5 - a final step -- binding arbitration -- to be initiated only by the  
36 housestaff association; and  
37
- 38 6 - sharing of arbitration costs.  
39

40 L. Disciplinary Hearings and Procedure  
41

42 The contract should provide a disciplinary procedure which guarantees

1 "due process" before any disciplinary action is taken against a housestaff  
2 member. Attachment A provides a procedure which may be appropriate or  
3 modified for use in a given institution. The procedure adopted should be  
4 set forth in full in the contract between the institution and the housestaff  
5 association.

6  
7 M. Training Programs and Patient Care Issues  
8

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

13  
14 There should be proscription against regular and recurrent performance  
15 of duties by housestaff officers unrelated to housestaff officer training.  
16

17 Patient care issues, educational training, and salary compensation for  
18 work and may be the subject for contract terms.  
19

20 Insofar as patient care issues are described in terms of reference to  
21 the physicians' job description, these frequently fall under contract working  
22 conditions. The quality of patient care services and facilities may be a  
23 specified feature of the training program contract, and can include such  
24 matters as adequate equipment, bedspace, clinical staffing, and clinical staff  
25 structuring.  
26

27 N. Other Provisions  
28

29 As indicated, the foregoing provisions are not all-inclusive. Depending  
30 upon the institution's size, location and affiliations, if any, and also  
31 depending upon the relationship between the institution and the housestaff  
32 association, other provisions may be included. For example:  
33

- 34 . payroll deduction of housestaff dues;
- 35
- 36 . maintenance of existing benefits and practices not otherwise  
37 expressly covered;
- 38
- 39 . housing, meals, laundry, uniforms, living-out and telephone allowances;
- 40
- 41 . adequate housestaff association office space, bulletin boards,  
42 secretarial assistance;
- 43
- 44 . housestaff association seminars or meetings.

ATTACHMENT ADISCIPLINARY HEARING AND PROCEDURE

- 1 1 - Before any housestaff member may be reprimanded, suspended, expelled,  
2 or suffer a denial of any right due by virtue of his appointment as  
3 a housestaff member or under any provision of this agreement, the  
4 housestaff member shall be entitled to the benefits of the procedures  
5 and appeals provided in this article.  
6
- 7 2 - Action seeking to reprimand, suspend, expel, or to deny to any housestaff  
8 member a right or privilege shall be commenced by the preparation of a  
9 complaint in writing setting forth the conduct complained of and the  
10 requested penalty. This complaint shall be filed with the Disciplinary  
11 Committee and a true copy shall be delivered personally to the housestaff  
12 member complained of.  
13
- 14 3 - The Disciplinary Committee shall appoint a Hearing Committee consisting  
15 of physicians - 40% of whom are housestaff officers to be selected by  
16 the housestaff association or the housestaff officers if there is no  
17 housestaff association. No member of the Hearing Committee shall be  
18 personally involved in the controversy described by the complaint. It  
19 shall be the duty of the Hearing Committee to conduct a fair and impar-  
20 tial hearing, pursuant to the provisions of this article and such fur-  
21 ther rules of procedure as the Committee may adopt for each hearing,  
22 which shall not be inconsistent with the provisions of this article.  
23
- 24 4 - The Hearing Committee shall set a time and place for a hearing on the  
25 complaint, which shall allow the accused housestaff officer a reason-  
26 able period of time to prepare his defense. The Hearing Committee may  
27 extend the time for the hearing by agreement of the parties or as the  
28 Hearing Committee may determine.  
29
- 30 5 - The accused housestaff member shall not be required to file a formal  
31 written defense to the complaint. The accused housestaff member may  
32 ask the Hearing Committee to order the complainant to make the com-  
33 plaint more specific by pointing out, in a written request filed with  
34 the Hearing Committee and served on the complainant, where the complaint  
35 is vague or ambiguous. If the Hearing Committee so orders, a more  
36 specific complaint must be promptly filed and served on the accused  
37 housestaff member.  
38
- 39 6 - Formal rules of evidence shall not prevail at the hearing conducted by  
40 the Hearing Committee; however, all evidence offered and considered  
41 at the hearing must be reasonably related to the facts and statements  
42 contained in the complaint. Both parties may be represented by attor-  
43 neys or by physicians of their choice at all stages of the procedure.  
44 No evidence shall be offered or considered by the Hearing Committee at  
45 any time except at a duly convened meeting of the Hearing Committee and  
46 while the accused housestaff member is present.  
47
- 48 7 - The accused housestaff member shall not be obligated to present any evi-  
49 dence by way of defense until the complainant has presented all of the

1 evidence in support of the complaint. The accused housestaff member  
2 shall not be compelled to be a witness against himself, but shall be  
3 given a reasonable opportunity and a sufficient period of time in which  
4 to present evidence in support of the defense. Immediately thereafter,  
5 the complainant shall be given an opportunity to rebut the housestaff  
6 member's evidence but not to offer new evidence which could have been  
7 presented previously.  
8

9 8 - After hearing all of the evidence, the Hearing Committee shall meet and  
10 decide if the evidence offered supports the complaint. If 75% or more of  
11 the Hearing Committee shall join in a decision they shall prepare a formal  
12 written document entitled "Findings of Fact" in which they state that the  
13 allegations of the complaint have or have not been proven and summarize the  
14 evidence in support of that finding. This document shall be filed with the  
15 Disciplinary Committee and a copy shall be delivered to both parties. If  
16 the Hearing Committee finds that the complaint has not been proven, no fur-  
17 ther action shall be taken on the same facts or occurrence. If the Hearing  
18 Committee finds that the complaint has been proven, the housestaff member  
19 shall have the right to appeal as provided below. If the Hearing Committee  
20 is unable to reach a decision, they shall so report and no further action  
21 shall be taken, but such decision shall not preclude a subsequent complaint  
22 on the same charge provided that additional evidence not previously  
23 available shall be offered in support of the complaint.  
24

25 9 - If the Hearing Committee has found the complaint to be proven, the accused  
26 housestaff member shall be entitled to appeal the decision to the full  
27 Disciplinary Committee. The accused housestaff member shall request  
28 an appellate hearing in writing and shall serve a copy of the request on  
29 the complainant.  
30

31 10 - A verbatim transcript of the proceedings before the Hearing Committee shall  
32 be prepared and filed with the Disciplinary Committee before the appellate  
33 hearing shall be convened. Each party also shall have the right to file a  
34 written argument with the Disciplinary Committee before the hearing date.  
35 A copy of any written argument shall be served on the other party. At the  
36 appellate hearing, both parties shall have an equal amount of time for oral  
37 argument. No additional evidence shall be offered at the appellate hear-  
38 ing. The Disciplinary Committee shall confine its considerations of the  
39 appeal to the records before the Hearing Committee and the appellate argu-  
40 ment.  
41

42 11 - The concurrence of 75% of the members of the Disciplinary Committee shall  
43 be required to affirm the decision of the Hearing Committee. Upon such  
44 concurrence, the Disciplinary Committee shall report its findings in writ-  
45 ing to the directors of the institution, together with a recommendation for  
46 punishment or penalty to be imposed. A copy of such report shall be de-  
47 livered to both parties. If the Disciplinary Committee shall not have the  
48 concurrence of 75% of its members in any decision, the matter shall be dis-  
49 posed of without further action upon filing the report of the Disciplinary  
50 Committee.

- 1 12 - Upon receiving the report of affirmance by the Disciplinary Committee  
2 and the recommendation of the Committee as to penalty or punishment,  
3 the Directors or their delegate(s) may impose punishment or penalty on  
4 the housestaff member , but not in excess of that recommended by the Dis-  
5 ciplinary Committee.  
6
- 7 13 - No housestaff member shall be subjected to any disciplinary action or  
8 penalty or loss of any compensation until completion of these proced-  
9 ures; provided, however, that a housestaff member may be suspended,  
10 but with pay, pending hearing and appeal where such suspension shall be  
11 required by substantial and imminent considerations of patient care.  
12
- 13 14 - The contract could provide as a final step in the disciplinary proceed-  
14 ings binding arbitration by a neutral medical expert, mutually selected.

RETREAT AGENDA

Page

Wednesday Evening, December 5

Cocktails and dinner - 6:30 pm - 8:30 pm

Convene 8:30 pm - 10:30 pm

I. Review of Ongoing Programs (Annual Report)

Thursday Morning, December 6

Breakfast - 8:00 am - 9:00 am

Convene 9:00 am - noon

II. Policy Issues

A. National Health Policy. . . . .	1
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C. Research	
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Coffee Break

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---	----

Lunch noon - 1:00 pm

Thursday Afternoon. 1:00 pm - 5:00 pm

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1. Number of M.D.'s . . . . .	38
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1. Physician Assistants. . . . .	48
2. Allied Health . . . . .	54
3. Continuing Education. . . . .	61

Coffee Break

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C. Public Hospitals & Limited Affiliates . . . . .	66
D. Reporting State Level Developments . . . . .	67

Cocktails - 5:00 pm - Dinner- 6:30 pm

Friday Morning, December 7

Breakfast - 8:00 am - 9:00 am

Convene 9:00 am - noon

IV. Liaison with Other Organizations

- A. CCME, LCME, LCGME
- B. AMA, AHA
- C. AAHC, Federation, Dentists, Nurses, etc.
- D. Federal Agencies
  - 1. DHEW (NIH, SSA, BHRD, etc.)
  - 2. VA
  - 3. White House, OMB
  - 4. Congress

Coffee Break

V. 1974 Annual Meeting . . . . . 68

A. Theme

B. Format

Lunch & Adjournment - noon - 1:00 pm



INTER-OFFICE MEMO

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

DATE September 3, 1974

TO: Executive Staff, Mrs. Waltraut Dube

FROM: E. Suter, M.D. *ES/Dome*

SUBJECT: Visit by Mr. José Adolfo de la Torre from Guadalajara

On Wednesday August 28, 1974 Mr. Jose Adolfo de la Torre, Director of Foreign Affairs of the Autonomous University of Guadalajara was here. Mrs. Dube and I spent about two hours with him during which time he presented programs and procedures of the Medical School of Autonomous University of Guadalajara and their relationship to American students. He also showed for ten minutes a promotional movie about the University dealing with its development and facilities.

The Universidad Autonoma de Guadalajara was founded in 1935 in protest against the official policy of President Cardenas at that time. The first faculty initiated was the Medical Faculty. The University had by 1962 a total of 3,000 students, which has increased by 1974 to 13,500 students. As of today there are slightly over 5,000 medical students.

The University provides the programs in many fields up to the master's level. The only Ph.D. is given in economics and doctorates are planned for the law and medical schools.

It seems that this University has developed rather rapidly in the following stages:

- A grant from the Department of State in 1966 of 3.5 million dollars permitted the development of a campus for the humanities and the exact sciences. This campus was opened in 1968.
- In March 1974 the construction of a new hospital was completed with the name of Hospital Angel Leaño. This hospital is presently used for clinical instruction of 3rd. and 4th. year medical students.
- Under planning is a "Ciudad de la Salud" with the hope of obtaining a loan of \$20,000,000 from the Interamerican Development Bank. Total cost of this Health City will be \$90,000,000. The first phase will be the construction of a Medical School building and a University Teaching Hospital followed by construction for the teaching of other health professions.

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The schedule of education in Mexico is about as follows:

Age 4 to 6	Kindergarden (2 years)
Age 7 to 13	Primary School (6 years)
Age 14 to 17	Secondary School (3 years)
Age 17 to 20	Preparatory School (3 years)

Preparatory School usually is taken at the University and ends up with an Associate's of Arts degree (bachiller). All programs in preparatory school are the same and there are no electives.

Students who want to enter the University must take a psycho-pedagogic exam and must, of course, have received passing grades in preparatory school.

Selection for the medical school at the Autonomous University is based on these two criteria. For American students the following is required:

- To have finished pre-medical requirements for entrance into a medical school in the United States.
- To have taken the MCAT at a score higher than 530.
- To have a grade point average of no less than 3.0.

As of September 1974 the medical school will accept 900 entering students of whom 450 will be Mexicans and 450 foreign students with approximately 400 of those coming from the United States.

In February of 1975 another 500 students will be accepted who will be predominantly foreign students and U.S. citizens.

The number of applicants for 450 places is between 600 and 700 Mexicans and for 400 acceptances of U.S. citizens is greater than 1,000.

The program of study is composed of four years that is eight semesters with four semesters devoted to the basic medical sciences and four to clinical medicine.

The payments required from American students are as follows:

- Registration fee \$1,000, this fee is payable upon application and will be returned in total should the student not be accepted. If, however, the student is accepted but does not attend the medical school he will lose this fee.
- For each semester, that is eight times \$2,000 plus 16 for sports activities.
- There is a single fee for validation of his records by the National University in Mexico City of \$88.
- As a comparison the Mexican student pays \$1,000 pesos (about US\$80)

for registration and last year payed \$6,000 pesos each semester (about US\$480).

The medical school accepts students both for the fall semester in September and for the winter or spring semester in February. All courses are given twice each year. All basic science courses give the lectures in sections of about 100 students each. Therefore, students have staggered weekly calendars and not all students attend the same classes at the same time.

American students upon acceptance are required to pass an examination in Spanish prior to entrance to medical school and if they fail they have to take a compulsory Spanish course. Apparently all instructions and all examinations are given in Spanish with the exception of certain "package programs" offered now in the third and fourth years. These are six-week packages in special topics such as cardiology, ophthalmology etc. presented by visiting lecturers from the United States. Originally Dr. De Angelo from Queens was in charge of this, now a Dr. Rose from Toronto is developing this program. Students can either take the regular clinical courses or enroll in the package program.

Apparently attendance at courses is checked by roll call and a student must have 80 per cent attendance over a semester time.

Examinations are given during each course and many courses give final examinations at the end of the semester. There are no final exams after the basic science period or after the total of eight semesters. They initiated a new grading system:

MB (muy bien)  
B (bien)  
S (suficiente)  
NO (no acreditado) This latter is a failing grade.

If at the end of the semester a student obtains a failing grade in a course on the regular examination, he can take a second exam two weeks later, should he pass then he will get credit for the course, if he fails again he can take an extraordinary examination three weeks later and if he fails again, he will have to repeat the course the following semester; although he can proceed with his other course work he must make up for this deficiency.

After the eight semesters or four years of study a student receives a diploma of the faculty of medicine indicating that he has fulfilled all course requirements of the medical school. This authorizes him to enroll in a one-year internship for which he has a choice of 88 hospitals dispersed throughout Mexico.

Following this internship he has to enroll in a one-year program of social service under the Mexican government. Apparently this one year can be reduced to six months either by taking a hardship assignment in a mountainous rural area or by forgoing the stipend during the social service period.

At the end of the social service each student has to take a professional examination officially administered and supervised by the National University in

Mexico City. This is an oral examination, and upon passage the student or graduate will receive the "Titulo de Medico Cirujano". He will receive from the national professional commission a "cedula" which gives him the right to practice medicine in Mexico.

United States citizens or any foreign citizen can only receive the titulo but not the cedula. Citizenship or at least five years of permanent residency are required for obtaining the cedula.

American citizens have certain options after receiving the diploma for which they have to pay a bond of US\$1,000. Then they can take a supervised clerkship program in the United States, and upon receiving a certificate from that medical school in which he has passed this clerkship program, he can enroll in social service and receive the titulo upon passage of the professional examination. Once the student returns for social service and/or the professional examination the US\$1,000 bond will be repaid to him. If he should not return he will lose the US\$1,000 bond.

A student who leaves Mexico after the four years of study or eight semesters and does not want to pay the US\$1,000 bond will not receive the diploma. He can request discharge from the University but he will have no paper in his hands; however, upon request by an institution his grades will be transmitted to it from the National University in Mexico City.

I believe the latter condition, namely of paying a US\$1,000 bond for the diploma, which is lost if the student chooses the Fifth Pathway rather than return, is not known to American Students, and I insisted that this should be specifically written into the descriptive pamphlet. Mr. de la Torre promised that this will be done.

We then discussed briefly some areas of conflict with American students. According to Mr. de la Torre they fall into three areas, namely, discipline, drug use, and political activity. For transgression of rules in any of these three areas a student can be dismissed immediately particularly if there is evidence of drug use or political activity. I presume disciplinary action is less likely. It is important to note that in the case of arrest for drug use according to Mexican law an individual is considered guilty until proven innocent. I would imagine that this particular difference from American law practice can be cause of considerable confusion, irritation and misunderstanding in the minds of American students. The problem is that if a student is accused of drug use the office of foreigners, which is a permanent office at the University of Guadalajara established by the Mexican Federal Government, will immediately recall the student's visa and he will lose all his rights of enrollment and of credit at the University. I believe this has happened to several American students.

This review of the University of Guadalajara was most helpful to me personally. The motivation of that University to accept American students is a financial one, in other words the tuition paid by American students permits a lower tuition to Mexican students and investment in a construction program. There

is no indication in the charter of the University that it should devote itself to the education of foreign students (international relationships). According to Mr. de la Torre there are presently 1,800 Americans enrolled at the University.

Mr. de la Torre promised that he would send us figures on enrollment and performance of American students and exact data on registration fees, tuition etc. comparing Mexican and American students. He also promised a list of American visiting professors who participated last year. We did not resolve the problem of discontent among many Americans and particularly attempts by the University to extort money from the students.

September 19, 1974

Memorandum

From: Prentice Bowsher

Subject: Health manpower legislation status report

This Memorandum, prepared for the Executive Council meeting of September 20, 1974, summarizes the current status of health manpower legislation, and compares similar House and Senate provisions for health professions education assistance. This information was not included in the prepared agenda because of the rapid pace of legislative developments.

#### Current situation

In the Senate, the health manpower bill is awaiting floor action, scheduled either for Friday, September 20, or for Monday, September 23. In reporting the bill, the Labor and Public Welfare Committee divided 10-5, and the dissidents are expected to take their opposition to the floor. One of the dissidents, Senator Beall, has gained Administration support for his position, which calls for low levels of capitation and national service agreements from a percentage of medical students.

In the House, the bill is still undergoing revision in the Public Health and Environment Subcommittee. Subcommittee action may conclude today. Following subcommittee approval, the bill must be considered by the full committee, the Rules Committee, and finally by the full House.

In a related health manpower development, President Ford on August 23 signed into law (PL 93-385) an emergency one-year extension of health professions and nursing loan assistance. This is designed to permit such loans while the omnibus legislation is under consideration. Funds for the loans are included in a pending supplemental appropriations bill.

### LEGISLATIVE PROVISIONS

#### Capital Support

##### Construction

Senate: Grants and guaranteed loans with interest subsidies are continued.  
Maximum grant assistance is 80 percent.  
Grant authorization is \$100 million, \$125 million, \$150 million thru fy 79  
Subsidy authorization is \$2 million, \$2.5 million, \$3 million thru fy 79

House: Grants and guaranteed loans with interest subsidies are continued.  
Maximum grant assistance is 80 percent.  
Grant authorization is \$50 million annually thru fy 77.  
Subsidy authorization is \$2 million, \$2.5 million, \$3 million.

Student Assistance

Health professions loans

Senate: Mandatory notification of loan forgiveness.  
Loan ceiling is tuition plus \$2,500 living expenses.  
Mandatory service agreement for loan and loan forgiveness.  
100 percent loan forgiveness for two years of service.  
Authorization is \$60 million annually thru fy 79.

House: Mandatory notification of loan forgiveness.  
Loan ceiling is tuition plus \$2,500 living expenses.  
Interest rate is increased from 3 to 7 percent.  
In addition to present forgiveness: 80% for 5 years primary care practice.  
Authorization is \$36 million annually thru fy 77.

National health service scholarships

Senate: Year-for-year service requirement.  
Authorization is \$25-35-45-55-65 million

House: Year-for-year service requirement.  
Authorizations are blank.

Loans, scholarships for USFMGs

Senate: Both extended for five years and tied to mandatory service agreements.

House: Both repealed.

Shortage area scholarships

Senate: Scholarship ceiling raised from \$5,000 to \$6,000.  
Authorization is \$4 million, \$5 million, \$6 million thru fy 79.

House: Repealed.

Health professions scholarships

Senate: Repealed.

House: Repealed.

Institutional Assistance

Capitation

Senate: No entitlement.  
\$3,250 for medical undergraduates.  
\$1,000 for physician extenders.  
Authorization for undergraduates (M & O) is \$186 million, \$194 million,  
\$201 million thru fy 79.  
Authorization for physician extenders (M & O) is \$2 million, \$3 million,  
\$4 million thru fy 79.

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House: No entitlement.

\$2,100 for medical undergraduates.

\$650 for physician assistants and for nurse practitioners.

Authorization for undergraduates (MOD) is \$161 million, \$165.5 million, \$168.5 million.

Authorization for PAs, nurse practitioners (MOD) \$5 million, \$6 million, \$7 million.

#### Conditions for capitation

Senate: Maintenance of effort and of enrollment.

Securing student service agreements.

Rolling enrollment increases either of undergraduates or of physician extenders.

Establish or expand projects in two of 13 specified categories.

House: Maintenance of effort and of enrollment.

Student agreements to repay capitation unless they serve in the National Health Service Corps.

One-time enrollment increase of undergraduates, or offer training as a physician assistant or as a nurse practitioner.

Approved plan for remote-site training, supported by at least 25% of capitation.

#### Start-up

Senate: Authorization is \$11 million annually thru fy 79.

House: Authorization is \$11 million annually thru fy 77.

#### Conversion:

Senate: Extend five years, a formula authorization.

House: Extend three years, a formula authorization.

#### Financial distress

Senate: Authorization is \$10 million annually thru fy 79.

House: Authorization is \$15 million annually thru fy 77.

### Specialized Assistance

#### Special projects

Senate: Expand the number of projects from 13 to 27.

Authorization is \$100 million annually thru fy 79, with at least 30% of appropriations earmarked for VOPP and public health schools.

House: Disadvantaged recruitment.

Authorization is blank.

Health professions education initiative awards

Senate: Authorization is \$75 million annually thru fy 79, with at least 30% of appropriations earmarked for VOPP and public health schools.

House: Revised for support of area health education centers which must include participation by a medical school and two other health personnel schools.

Authorization is \$30 million, \$40 million \$50 million.

Family medicine

Senate: Authorization is \$40 million annually thru fy 79.

House: Authorization is blank.

USFMGs

Senate: AAMC remedial program.

Authorization is \$5 million, \$10 million, \$15 million thru fy 79.

House: AAMC remedial program.

Authorization is blank.

Computers

Senate: Repealed.

House: Authorization is blank.

Graduate training for physicians and dentists

Senate: Authorization is \$15 million annually.

House: Repealed.

Teacher training

Senate: Repealed.

House: Repealed.

Emergency medical services training

Senate: No provision

House: Authorization is blank.

Educational innovation

Senate: No separate provision (included in special projects).

House: Authorization is blank.

Other Provisions

Senate

The Senate bill also includes new programs for the support of clinical pharmacology in medical schools and for the development of bilingual health training clinical centers in affiliation with university medical centers.

The Secretary is directed to conduct a study of medical school admissions tests as they relate to persons with limited English-speaking ability.

The bill also establishes national certification of housestaff for reimbursement under federal programs, and establishes a program of minimum national standards for licensure and relicensure of physicians.

House

The House bill also provides for project grants to establish departments of family medicine.

The House bill also calls for a study of specialty distribution.

Both bills

Both bills modify the present structure of the national advisory council, and attempt to prevent decentralization of the administration of health manpower programs.

PHYSICIAN MANPOWER AND DISTRIBUTION

The Primary Care Physician

PRELIMINARY REPORT  
NOT OFFICIAL POLICY

(A Report of the Committee on Physician Distribution  
to the Coordinating Council on Medical Education)

In the late 1950's, concern was expressed that an insufficient number of physicians would be available in the future to meet the health care requirements of the public. The physician-population ratio in 1959 was 149/100,000.\* The total number of physicians was 235,000. Osteopathic physicians numbered 14,100. Seven thousand four hundred medical students were graduated from American medical schools.

A Consultant Group appointed by the Surgeon General of the U.S. Public Health Service stated in a report (Bane Report)<sup>1</sup> that maintenance of "the present ratio of physicians to population is a minimum essential to protect the health of the people of the U.S." The report also stated, "To maintain the present ratio of physicians to population will require an increase in the graduates of schools of medicine and osteopathy from the present 7,400 a year to some 11,000 by 1975." At the time concern was also expressed about the increasing number of specialists, the decreasing number of general practitioners, and a decrease in the total number of physicians who served families as primary care physicians.

In 1967, a National Advisory Commission on Health Manpower<sup>2</sup> recommended that "The production of physicians should be increased beyond presently planned levels by a substantial expansion in the capacity of existing medical schools and by continued development of new schools."

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\*. The ratio published originally in the Bane Report was 141/100,000. In 1963, a national conference on physician statistics revised the categories of physicians and population to be counted. Using the new agreement, the 1959 physician/population ratio became 149/100,000.

The schools of medicine have responded to the challenge for additional physicians, increasing substantially both in number and in size (Tables I, II). A report entitled "AAMC Program for the Expansion of Medical Education"<sup>3</sup> outlined a goal of 15,000 first-year medical students by the bicentennial year of 1976. This figure is likely to be met in 1975. Similarly, the goals announced in the Bane Report have all been achieved, exceeded or are within reach before the 1975 deadline.

Currently, the net rate of increase of the physician population is about 3% per year, while that of the general population is about 1% per year (Table III). This disproportionate rate of growth would seem to indicate that an appropriate balance will be achieved between the total number of physicians and the population in the years ahead. However, many factors could alter the time at which such a balance is achieved, including the advent of national health insurance, policies for the reimbursement for services, changing demands for health care, and different professional patterns for the delivery of care.

If the present output capacity of American medical schools is maintained and if the influx of foreign medical graduates continues at its present level, the total number of physicians will approach 500,000 by 1980. If the number of foreign medical graduates is reduced substantially in future years, the total number could be considerably smaller. If, for example, no foreign medical graduates were admitted after 1975, the total number of physicians in 1980 might be smaller by 40,000 or more. If continued growth in the output capacity of American medical schools occurs, the number will increase.

The production of numbers of physicians is being addressed with good results, but there is also need for an effective geographic and specialty distribution.

Ideally physicians should be evenly accessible to the population in all geographic settings. This is not the case, for physician distribution, like that of

many segments of the population, has been influenced markedly by economic and social conditions and by urban and rural dynamics (Table IV). The result has been dramatic differences in the concentration of practicing physicians in various population areas (Table V).

Of considerable importance is the problem of having the right physician in the right place at the right time. A psychiatrist is of limited utility when obstetrical services are needed. Excessive numbers of secondary and tertiary care specialists will not meet the need for an adequate number of primary care physicians. Obviously the distribution of physicians by medical specialty is comparable in importance to the total number and their geographical distribution.

One of the most important factors in achieving a proper balance of physician manpower is the availability of primary care physicians to provide access to the health care system. The progressively declining number of primary care physicians in this country has evoked wide-spread concern, which is manifest in the attention given to this subject by private organizations and public agencies, including the federal and state governments.

The present situation has evolved because of the increasing number of specialists other than primary care physicians. Adjustments in the rate of production of specialists desirably would be effected by the creation of appropriate incentives rather than by the imposition of regulations and arbitrary controls. The present need for readjustment, however, is sufficiently urgent that a long-range program of incentives should be developed as promptly as possible.

Specialism has developed spontaneously since World War II as a result of the significant increase in biomedical knowledge, potent drugs, and sophisticated diagnostic and therapeutic techniques. This has occurred largely because of the

extensive support of biomedical research by the federal government and foundations since the late forties. As a result of the response to this national mandate, the faculties of medical schools and the staffs of their associated teaching hospitals became composed almost exclusively of non-primary care specialists and subspecialists. The visibility of the primary care physician dwindled to the point where developing physicians choosing a career found no pattern that displayed in an attractive fashion the professional role of the primary care physician. Until the establishment of the American Board of Family Practice in 1969, there was no specialty board that emphasized certification for primary care and provided professional stature and prestige equivalent to that enjoyed by the other recognized specialties.

A primary care physician (or group of physicians) is one who establishes a relationship with an individual or a family for which he provides continuing surveillance of their health needs, comprehensive care for the acute and chronic disorders which he is qualified to care for, and access to the health care delivery system for those disorders requiring the services of other specialists. The physicians who meet this definition today are general/family physicians, general internists, and general pediatricians. To some degree, other specialists, such as cardiologists, gastroenterologists, obstetricians, and general surgeons, also provide primary care, especially access to the health care system. They are not, however, identified either by education or practice as fulfilling consistently all of the requirements of primary care physicians.

Many studies have been made in an attempt to determine the numbers and proportions of physicians needed in each of the various specialties, but there has been no general agreement on the optimal composition of the physician population. However, most observers of the health care field appear to be in agreement that:

1) there is currently an inadequate number of physicians engaged in the delivery of primary care; 2) there is probably an adequate number, or even an excessive number, of physicians engaged in the delivery of certain types of secondary and tertiary care; 3) the proportions of graduates now engaged in graduate medical education, and the nature of that education, are such that the percentage of physicians engaged in primary care is likely to decrease and the percentage engaged in secondary and tertiary care is likely to increase.

The problems related to the education of various kinds of primary care physicians are somewhat different and are accordingly separated in their consideration below.

#### GENERAL/FAMILY MEDICINE

In recent years there has been a progressive decline in the number and proportions of American physicians who identify themselves as engaged in general or family practice. In 1931, there were 112,000 physicians who classified themselves as general practitioners on AMA's annual directory questionnaires. In 1960, the number had dropped to 75,000; in 1965, it was 66,000; at the end of 1972, it was less than 55,000. While general practice and family practice are not necessarily the same, the decline in the number of general practitioners is certainly indicative of a decline in the number of primary care physicians.

In years past, most physicians entered general practice directly from medical school or after a one-year rotating internship. While there were some general and family practice residencies in existence in the 1950's and 1960's, they were not very successful in attracting American graduates. There was, of course, no recognition afforded those who completed the residencies, since there was no specialty board in that field. As more and more American graduates

entered some kind of residency, the trend away from general practice was accentuated. By the end of 1971, only 1.6% of all of those engaged in graduate medical education were in general or family practice residencies.

*Since the American Board of Family Practice was established in 1969, the concept of family practice has achieved considerable visibility and acceptance. The Board, however, should define more clearly the characteristics and contour of the specialty since it is interpreted in a variety of ways.*

A new group of residency programs in family practice was established in 1970. These have grown phenomenally, from 62 approved programs with 131 first-year residents in 1970 to 164 approved programs with 756 first-year residents in 1973,\* but their proportion of the total field of graduate medical education is still quite small. It is too early to tell whether the early rapid rate of growth will be sustained.

The Millis Commission pointed out that the average age of general practitioners was above that for other physicians in 1965. The average age of general and family practitioners has been increasing over the past decade. Table VI demonstrates the changing age distribution of GP/FP physicians. With most recent graduates entering other fields, the difference has undoubtedly become greater since that time. Consequently, even though the recent growth of family practice residencies looks promising, the current low percentage of those in residencies, together with the attrition from the higher age population of general practitioners, indicates that the proportion of physicians engaged in general/family practice is certain to decline further over the next few years. Only a major change in the career goals of American graduates and continued expansion of the number of family practice residencies will reverse the trend.

.There are many factors which influence the career choices of American

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\* 1974 figures to be supplied as soon as they are available.

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medical graduates, including such things as the nature of the specialty field, its professional challenge and recognition, the environment for practice, monetary rewards in proportion to time demands and service provided, and the availability of professional associates and supporting services. Although there is good evidence today that these factors have been addressed, further effort is required so that family practice will continue to be a desirable field by growing numbers of medical students.

However, student interest is only one factor which will affect the growth rate of family practice residency programs. A very important determinant will be not only the availability of qualified faculty, currently in short supply, but the excellence of the educational programs themselves. Another will be the rate of development of satisfactory models of family practice and appropriate administrative units for the new programs. Substantial additional financial support will be necessary to enable the development of the necessary personnel, resources, and facilities.

#### INTERNAL MEDICINE AND PEDIATRICS

Residencies in internal medicine and pediatrics have enjoyed sustained popularity over many years. In 1962, 17.7% of all residents were in internal medicine and 5.9% in pediatrics, compared with 13% and 5% respectively engaged in practice in those fields.<sup>4</sup> In 1966, 17% of all residents were in programs in internal medicine and 7% in pediatrics; the proportions engaged in practice in those fields were still 13% and 5% respectively.<sup>5</sup> In 1972, the percentage in residencies in internal medicine had increased to 23.9 and in pediatrics to 7.7. The proportions in practice had increased to 13.5% and 5.5% respectively.<sup>6</sup>

To some extent the growth in internal medicine and pediatrics may offset the decline in general/family medicine. However, there is evidence to show that substantial numbers of internists and pediatricians extend their training into

subspecialty fields and are consequently being prepared to function principally as secondary and tertiary care physicians rather than as primary care physicians (Tables VII and VIII). Once again, this is not to deny that subspecialists provide some primary care, but simply to point out that their education does not direct them toward primary care.

Prior to 1972, the American Board of Internal Medicine had awarded 23,023 certificates. In addition, 2,697 certificates had been awarded in four subspecialty areas; the number of subspecialty certificates was therefore 11% of the number of general certificates. During 1972, 4,378 certificates were given by the American Board of Internal Medicine. The large number was in part the result of a change in certification policy during the previous year. During the previous period 1,611 certificates were authorized in eight subspecialty areas. This number is equivalent to 37% of the number of general certificates issued in 1972. The increment in subcertification has increased the ratio of subcertificates to general certificates from 11% to 15%. Some of the physicians receiving certificates in subspecialty areas were already practicing and do not represent an increment to the subspecialty manpower pool.

Both the American Board of Internal Medicine and the American Board of Pediatrics in recent years have developed additional categories of subspecialization for which certification is provided and more are planned. At the present time, Internal Medicine provides certification in cardiology, pulmonary disease, gastroenterology, endocrinology and metabolism, nephrology, hematology, infectious diseases, medical oncology, and rheumatology. Pediatrics provides certification in cardiology, hematology-oncology, and nephrology. The Conjoint Board of Allergy and Immunology, recently established, certifies physicians in this specialty.

It is almost certain that with additional opportunities for certification in subspecialty areas a progressively larger percentage of those certified in internal medicine and pediatrics will seek certification by a subspecialty board. If this occurs, there may be proportionately fewer internists and pediatricians whose major interest is to provide primary care. An appropriate balance would be desirable, especially since the need for an increased number of primary care physicians is so evident.

*The boards of Internal Medicine and Pediatrics can exert considerable influence upon the attainment of this balance if they re-examine their requirements for admission to their certifying examinations so that the educational programs and careers of internists and pediatricians interested in primary care will have at least the same professional prestige as the subspecialty categories of internal medicine and pediatrics. The Liaison Committee on Graduate Medical Education, its sponsoring organizations, and the appropriate residency review committees can, through the "Essentials" and the review of residency programs, devise methods for emphasizing the desirability and needs of strong and attractive educational experiences for internists and pediatricians interested in primary care.*

The preceding discussion indicates that the physician/population ratio is increasing rapidly and very likely will attain an acceptable figure by 1980. The distribution of physicians, however, by specialty and location will not be changed significantly. A progressively larger proportion of physicians certified in Internal Medicine and Pediatrics are entering subspecialty fields. Foreign medical graduates already comprise a significant part of the practicing medical profession and the numbers increase yearly. There is a well documented need for additional primary care physicians which in part could be met by providing greater opportunities, incentives, and security for students

and physicians interested in careers devoted to the teaching and provision of primary care.

This report is directed solely to ways in which the educational endeavors of schools of medicine and graduate educational programs may expand the number of primary care physicians. Many factors in addition to education can, and will, influence the numbers and distribution of primary care physicians. For example, policies and programs for the reimbursement of physicians services have a considerable bearing upon not only the numbers of physicians committing themselves to careers in primary care, but also the numbers who will select careers in other specialties. The developing imminence of national health insurance will almost certainly initiate discussions concerning reimbursement policies.

#### RECOMMENDATIONS

A. As a national goal, schools of medicine should be encouraged to accept voluntarily a responsibility for providing an appropriate environment that will motivate students to select careers related to the teaching and practice of primary care. An initial national target of having 50% of graduating medical students choose careers as primary care specialists appears reasonable.

Schools of medicine accepting this responsibility may direct their attention to one or both of the following mechanisms in order to increase the output of generalists: (1) The development of instructional programs and services for family medicine, or (2) the reorientation of departments of medicine and pediatrics.

1. Medical schools establishing family medicine administrative units are obligated to provide the necessary resources for the development of family practice curricula

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and the operation of family practice clinical services in order that medical students may be exposed to suitable career models in family medicine. Financial support from federal and state governments, as well as support from private foundations and the institutions themselves, should be made available for the support of such activities.

The federal and some state governments as well as private foundations have already recognized that the development of the specialty of family practice could, over the course of the next few years, increase the number of primary care physicians in a significant way. Forty-nine schools of medicine have also recognized the need and have responded by creating departments of family medicine or other suitable administrative units.

Schools of medicine seriously interested in promoting the development of primary care physicians through the specialty of family practice recognize the need to establish administrative units that have the same professional stature as other administrative units in the school. In most instances, this requires the addition of new faculty members with primary care skills, and the training of others. If success is to be achieved, other clinical disciplines in a school must be supportive by contributing teaching time and effort to family medicine. These disciplines should also instill in their own residents appropriate attitudes recognizing the consultant's role in relationship to the primary care specialist who provides continuity of care for the patient. The schools will need financial support for the development of new faculty, curricula, and space. Monies already committed for the support of the schools cannot easily be diverted for this purpose.

2. Medical schools should encourage their Departments of Internal Medicine and Pediatrics to have among their goals the creation of an environment that emphasizes the need for and the development of internists and pediatricians for primary care. The professional and

material resources necessary to achieve such goals must also be provided.

The incorporation into the faculty of academically oriented general internists and pediatricians with the same privileges and stature afforded the subspecialists in these departments would accomplish a great deal in changing the image of medicine and pediatrics presented to undergraduate students.

B. Institutions responsible for graduate education, including university-affiliated hospitals, should be encouraged to establish residencies in family practice, internal medicine and pediatrics, with orientation toward primary care. These programs should have equal professional status with educational programs in the medical and pediatric subspecialties.

Although many of the family practice residencies will be located in hospitals whose essential commitment is the delivery of care to a community, it is essential that a family practice unit exist in a university hospital if the desirable features of a career in family practice are to be appreciated by students and young physicians.

In a few institutions, many of the physical, patient, and professional resources are already in existence and require only re-allocation for new objectives and programs. In most, new facilities and professional staff will be necessary to establish successful educational programs.

*Special emphasis should be given to the creation and financial support of an appropriate ambulatory care setting for the teaching of family practice, internal medicine and pediatrics with orientation toward primary care. Within the ambulatory care setting, physicians should learn to function with other health professionals in order to increase the overall effectiveness and quality of care.*

State governments and their agencies responsible for health and education should be aware of the documented fact that the retention of physicians within their jurisdiction is to a significant degree dependent upon the location, the type, and quality of residency programs within the state. Financial support directed to the development of high quality residencies in family practice, and in internal medicine and pediatrics with orientation toward primary care, would almost inevitably be a sound investment on behalf of the people within a state.

C. Educational institutions should be encouraged to develop better methods for the delivery of primary care, including ways of increasing efficiency and effectiveness of primary care physicians and educating physicians to work with other members of the health care team, so that efficient and complete health care may be provided.

This is particularly important because it is impossible to predict precisely the future patterns of the delivery of health care. While it seems likely and indeed desirable that a pluralistic system of health care delivery will continue to exist, it is possible that there will be a strong movement toward the expansion of group practice and the development of health maintenance organizations. Obviously, the profession and its educational institutions must be prepared to respond to such changes with innovative and imaginative educational programs relevant to demonstrated needs.

*However the patterns of care develop in the future, it must be emphasized that there is currently a serious need for more primary care physicians and this need will increase in the years immediately ahead. Major efforts and financial support should therefore be provided for increasing the number of family physicians, and internists and pediatricians committed to the delivery of primary care. Support for this development should be provided in addition to, and not at the expense of,*

*the support for existing programs.*

REFERENCES

1. *Report of the Surgeon General's Group on Medical Education. Physicians for a Growing America*, U.S. Department of Health, Education, and Welfare, Public Health Service, October, 1959.
2. *Report of the National Advisory Commission on Health Manpower*. Washington, D.C., U.S. Government Printing Office, Vol. I, November, 1967.
3. *AAMC Programs for the Expansion of Medical Education. The Journal of Medical Education* 46:105-115, February, 1971.
4. *Medical Education in the United States. The Journal of the American Medical Association* Vol. 186, p. 684, November, 1963.
5. *Medical Education in the United States. The Journal of the American Medical Association* Vol. 202, 8:778, November, 1967.
6. *Medical Education in the United States. The Journal of the American Medical Association* Vol. 226, 8:935, November, 1973.

TABLE I

STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS\*

<u>YEAR</u>	<u>NUMBER OF SCHOOLS</u>	<u>1ST YEAR ENROLLMENT</u>	<u>TOTAL ENROLLMENT</u>	<u>GRADUATES</u>
1930-31	76	6,456	21,982	4,735
1940-41	77	5,837	21,379	5,275
1950-51	79	7,177	26,186	6,135
1960-61	86	8,298	30,288	6,994
1970-71	103	11,348	40,487	8,974
1971-72	108	12,361	43,650	9,551
1972-73	112	13,726	47,546	10,391
1973-74	114	14,044***	51,000**	11,862**

\*Table developed from information published annually, *Medical Education in the United States*,  
The Journal of the American Medical Association.

\*\* Estimates

\*\*\* AAMC DATAGRAM

TABLE II

AVERAGE SIZE OF MEDICAL SCHOOLS, 1930-1974<sup>±</sup>

<u>YEAR</u>	<u>NUMBER OF SCHOOLS*</u>	<u>AVERAGE 1ST YEAR ENROLLMENT*</u>	<u>AVERAGE TOTAL ENROLLMENT*</u>	<u>AVERAGE GRADUATES**</u>
1930-31	76	85	289	74
1940-41	77	76	277	79
1950-51	79	91	331	85
1960-61	86	96	352	86
1970-71	103	110	393	101
1971-72	108	114	404	102
1972-73	112	123	425	106
1973-74	114	121	447***	109***

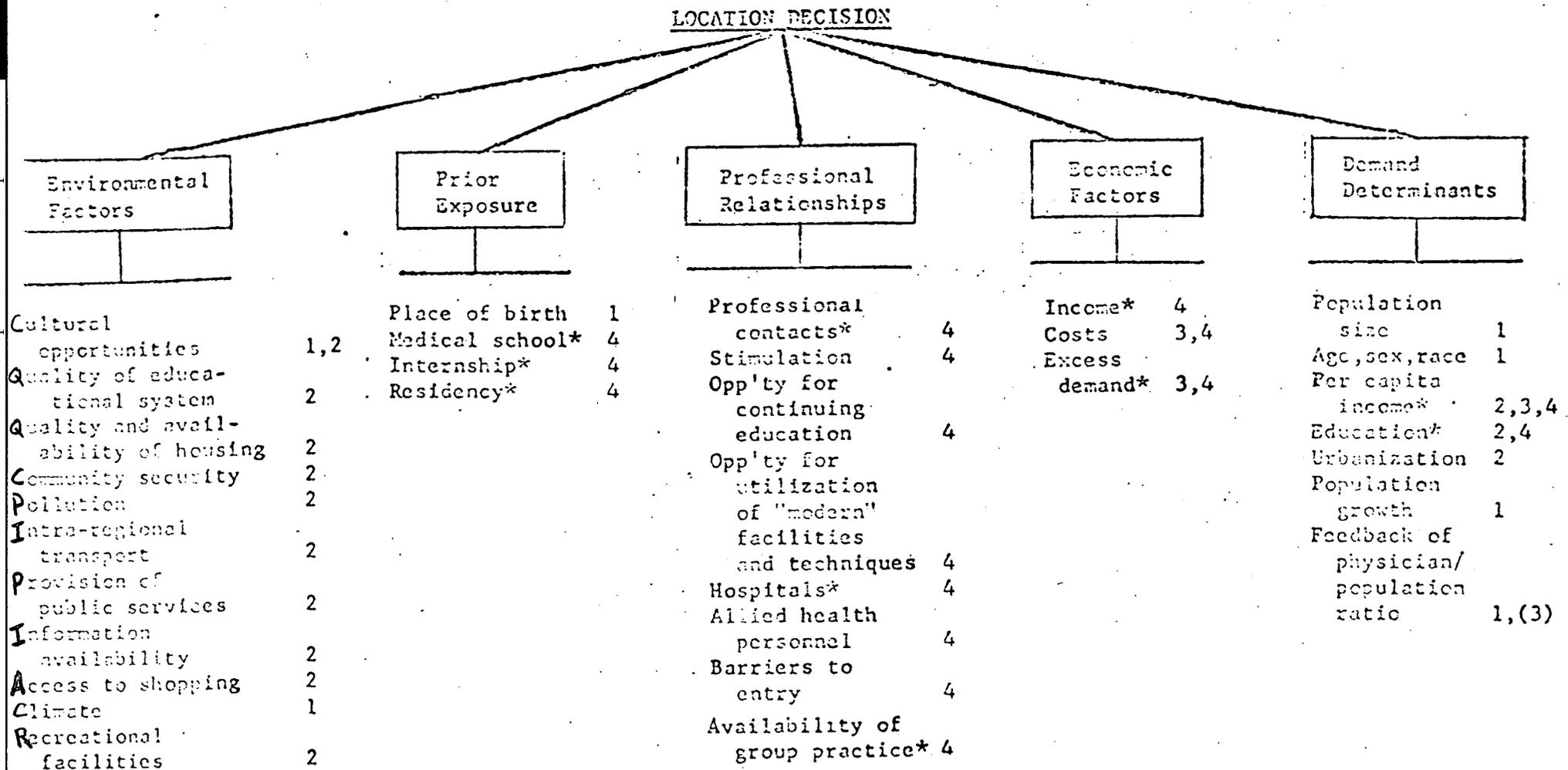
\* All medical schools.

\*\* Excludes schools not graduating students.

\*\*\* Estimates.

<sup>±</sup> Table developed from information published annually, *Medical Education in the United States*, The Journal of the American Medical Association.

TABLE IV

POLICY POTENTIAL OF FACTORS IN LOCATION DECISIONSSource

McFarland, J.: Toward an Explanation of : Geographical Location of Physicians in The United States. In: Contributions to a Comprehensive Health Manpower Strategy, Chic. AMA Center for Health Services, Research Development. Rev. July, 1973 - pp 29-67

Classification Code:

1. Not subject to policy manipulation
2. Inefficient policy variable
3. Infeasible variable for policy
4. Potential policy variable

\* Indicates variable, in the subset of policy alter. gives, which seems to be very important

TABLE V

CONCENTRATION OF PRACTICING, NON-FEDERAL  
PHYSICIANS IN POPULATION AREAS

<u>Metropolitan Area</u>	<u>Resident Population*</u>	<u>Total Non-Fed. Physicians+</u>	<u>Physicians Per 100,000 Pop.</u>
Boston, Mass.	3,388,300	7,624	229
Los Angeles, Calif.	7,062,600	12,632	177
Knoxville, Tenn.	409,500	540	132
Peoria, Ill.	344,800	361	105
Abilene, Tex.	117,200	111	95
Biloxi, Miss.	135,200	108	80
Elkhart, Ind.	132,200	97	74

\*As of Dec. 31, 1971.

+As of Dec. 31, 1972.

This table constructed from information published in *Distribution of Physicians in the U.S., 1972, Vol. 2/Metropolitan Areas*. AMA Center for Health Services Research and Development.

Table VI

FP/GP AGE GROUPINGS, 1963 and 1967\*

<u>Age Group</u>	<u>1963</u>	<u>1967</u>
Over 50	36,993 (50.28%)	36,883 (53.59%)
Under 50	<u>36,585</u> (49.72%)	<u>31,947</u> (46.41%)
Total	73,579 (100%)	68,830 (100%)

\*From *Selected Characteristics of the Physician Population, 1963 and 1967*. AMA Department of Survey Research, 1968.

TABLE VII

CHANGE IN SPECIALTY DISTRIBUTION

<u>PRIMARY CARE SPECIALTIES</u>	<u>1965*</u>	<u>1972*</u>	<u>% CHANGE</u>
INTERNAL MEDICINE	38,490	47,994	
PEDIATRICS	15,665	19,610	
GENERAL AND FAMILY PRACTICE	71,366	55,348	
	125,721	122,952	- 2.2
<u>MEDICAL AND PEDIATRIC SUB-SPECIALTIES</u>			
ALLERGY	910	1,638	
CARDIOVASCULAR	1,901	5,883	
GASTROENTEROLOGY	633	1,839	
PEDIATRIC ALLERGY	82	383	
PEDIATRIC CARDIOLOGY	146	514	
PULMONARY DISEASE	1,226	2,065	
	4,898	12,322	+ 151.6
<u>% CHANGE IN RATIO OF MEDICAL AND PEDIATRIC SUB-SPECIALISTS TO TOTAL NUMBER OF INTERNISTS AND PEDIATRICIANS.</u>	9.0	18.2	
<u>PRIMARY CARE SPECIALTIES</u>	125,721	122,952	
<u>MEDICAL AND PEDIATRIC SUB-SPECIALTIES</u>	- 4,898	- 12,322	
	120,823	110,630	- 8.4
<u>SURGICAL SPECIALTIES</u>	76,147	91,058	+19.6
<u>OTHER SPECIALTIES</u>	70,809	94,571	+33.6

\*Distribution of Physicians in the U.S., 1965, 1972. AMA Center for  
Health Services Research and Development

TABLE VIII

## DISTRIBUTION OF PHYSICIANS IN USA AND POSSESSIONS

Specialty	1965 No.*	%		1972 No.*	%	
General and Family Medicine	71,366	24.45	} 43.06	55,348	15.52	} 34.48
Internal Medicine	38,690	13.25		47,994	13.46	
Pediatrics	15,665	5.36		19,610	5.50	
Allergy	910	0.31		1,638	0.46	
Anesthesiology	8,644	3.00		11,853	3.32	
Aviation Medicine	788	0.27		921	0.26	
Cardiovascular Disease	1,901	0.65		5,883	1.65	
Child Psychiatry	817	0.28		2,268	0.64	
Colon & Rectal Surgery	650	0.22		649	0.18	
Dermatology	3,538	1.21		4,227	1.19	
Diagnostic Radiology	38	0.01		2,076	0.58	
Forensic Pathology	51	0.02		194	0.05	
Gastroenterology	633	0.22		1,839	0.52	
General Preventive Medicine	971	0.33		840	0.24	
General Surgery	27,693	9.49		30,989	8.69	
Neurological Surgery	2,045	0.70		2,753	0.77	
Neurology	2,174	0.74		3,494	0.98	
Obstetrics & Gynecology	16,833	5.77		20,202	5.67	
Occupational Medicine	1,745	0.59		2,506	0.70	
Ophthalmology	8,397	2.88		10,443	2.93	
Orthopedic Surgery	7,549	2.59	} 56.94	10,356	2.90	} 65.52
Otolaryngology	5,325	1.82		5,662	1.59	
Pathology	8,437	2.89		11,024	3.09	
Pediatric Allergy	82	0.03		383	0.10	
Pediatric Cardiology	146	0.05		514	0.14	
Physical Medicine & Rehab.	1,084	0.37		1,551	0.44	
Plastic Surgery	1,133	0.39		1,786	0.50	
Psychiatry	17,888	6.13		22,570	6.33	
Public Health	2,680	0.92		2,906	0.82	
Pulmonary Disease	1,255	0.42		2,065	0.58	
Radiology	9,553	3.27		11,910	3.34	
Therapeutic Radiology	56	0.02		931	0.26	
Thoracic Surgery	1,477	0.51		1,927	0.54	
Urology	5,045	1.73		6,291	1.76	
Other Specialties	--	--		7,010	1.97	
Unspecified	9,750	3.34		8,290	2.33	
Inactive	13,279	4.55		20,110	5.64	
Not Classified	3,566	1.22		12,356	3.47	
Address Unknown	--	--		3,165	0.89	
	291,825	100.00		356,534	100.00	

\* Distribution of Physicians in the U.S., 1965, 1972. AMA Center for Health Services Research and Development.

RECOMMENDATIONS OF ACTION RELATING  
TO PHYSICIAN MANPOWER DISTRIBUTION

Health Services Advisory Committee  
Association of American Medical Colleges  
Department of Health Services

The Health Services Advisory Committee met on September 11, 1974 to review the Association's position on the national problem of maldistribution of physicians on both specialty and geographic bases.

Consideration was given to elements of the health manpower bills now before both houses of Congress. A review was concluded of AAMC testimony to date before Senate and House subcommittees,<sup>1</sup> and of AAMC position statements contained in the "green book".<sup>2</sup> Furthermore, the recommendations from the report of the CCME on the Primary Care Physician-Physician Manpower and Distribution<sup>3</sup> were reviewed, and the status of that report with respect to ratification by the parent organization was discussed. The Committee further reviewed the recommendations of the Task Force on FMG's, recently approved by the Executive Council, as they relate specifically to the number of graduate education positions to be approved in the future.<sup>4</sup>

The Committee accepted the concept that medical education programs at the graduate level have a far greater impact on physician career choice (and therefore have a more magnified effect on specialty and geographic maldistribution problems) than programs initiated at the undergraduate education level. Therefore, attention was given primarily to programs which academic medical centers are currently conducting, or should be encouraged to introduce, at the graduate education - residency - level.

Senate Bill S. 3585 contains a section establishing a National Council (section 790) to supervise the study of physician specialty distribution in the U.S., and a section establishing Regional Councils of Postgraduate Physician Training (section 792), all for the purpose of eventually developing a certification program to establish a finite number of postgraduate training positions by specialty and by region. To date, the AAMC has opposed<sup>1</sup> such measures as proposed in S. 3585 as being redundant or premature in view of the current national study conducted under the direction of the IOM, which should be completed in 1976, and in view of recommendations made by the Task Force on FMG's, especially that calling for a study<sup>5, 6</sup> of the impact on the nation's teaching hospitals of a sharp decrease in total number and/or marked change in distribution of certified residency positions.

The Committee supports the AAMC's opposition to the development at this time of a National Council and Regional Councils on postgraduate physician training. The Committee believes that the rationale for this position -- to await first the results of the IOM study and the teaching hospital impact study -- is quite valid. However, the Committee believes that the AAMC can reasonably take a stronger and more aggressive position on this

issue, and the Health Services Advisory Committee, therefore, submits the enclosed recommendations for Council action. Recommendation number one takes note of the fact that many academic medical centers have already developed action programs which deal with the issues of geographic and specialty physician distribution, and that the AAMC should go on record as supporting these individual initiatives. Also, through endorsing a program of appropriate technical assistance, the AAMC should support other institutions who wish to address these problems through corporate management of the postgraduate physician training programs in consideration of regional as well as national needs. In essence, these actions would be set in motion concurrent with the IOM study. There is already in place the "wider forum" for consideration of these issues, i.e. the CAS-COD-COTH joint meeting on Wednesday, November 13, 1974, at the AAMC Annual Meeting.<sup>7</sup> It has been suggested that the Chairman of the Health Services Advisory Committee be added to the list of panelists at that session.

As a sequel to the above discussion, the Committee took note of the fact that all efforts to improve physician manpower distribution on a national or regional basis would be seriously handicapped in the planning stages without a readily accessible valid data base containing description of current practice patterns. Committee members expressed concern over the relative inaccessibility of such data and questions concerning the accuracy of the data base as it is currently maintained. Therefore, the second recommendation for Council action supports the establishment of a national health professions data base along the lines of section 707<sup>o</sup> of the Senate Bill S. 3585.\*

\*This section will quite obviously provoke strong AMA opposition.

1 Memorandum #74-26 to the Assembly from John A. D. Cooper, M.D., Subject: Health Manpower Legislation Review and Outlook.  
Note especially page 3. National certification of housestaff (Senate Bill) (enclosed)

2 Issues, Policies, and Programs, AAMC

3 Recommendations from the Report of the CCME, Physician Manpower and Distribution, The Primary Care Physician.

4 "The widely different standards of admission (Foreign vs. U.S. graduates) are paralleled by a wide spread of quality offered in different programs of graduate medical education. The large surplus of positions in graduate programs over the number of medical graduates from U.S. medical schools provide a stimulus for immigration of graduates of foreign schools. Criteria for approval of programs for graduate medical education, therefore, should emphasize the educational component of such programs and the number of first year positions available in graduate education should exceed only slightly the expected number of graduates from U.S. medical schools." (underline added)

5 "Medical services in many teaching hospitals depend on the services rendered by FMG's. To avoid any potential disruption of patient care services in these institutions by measures resulting in a reduction of FMG's in graduate medical education, it will be necessary to assess the degree of dependence on these hospitals and to explore new ways for providing services presently rendered by housestaff." (underlines added)

6 The Committee, during the course of further business on September 11, agreed to accept the offer for service as an advisory committee to this study, a part of a larger grant proposal by the AAMC to the Commonwealth Fund.

7 CAS-COD-COTH joint meeting agenda. (enclosed)

8 S. 3585, section 707. (enclosed)

## RECOMMENDATION #1

The Health Services Advisory Committee recognizes that individual institutions have made strong efforts in the direction of examining and beginning to deal with physician manpower needs, geographically and by specialty. However, the crucial importance of the geographical and specialty maldistribution of physician manpower in the USA is such that more concerted regional and national efforts must be made by the academic medical center to help solve this problem. The Committee recognizes that the academic medical centers have a major responsibility to examine their own programs in concert with regional and national groups. The Committee therefore recommends that the AAMC immediately provide a wider forum for the urgent consideration of these issues and seek to organize technical assistance for constituent institutions for the achievement of these purposes.

## RECOMMENDATION #2

The Health Services Advisory Committee recommends to the Association of American Medical Colleges that it support the establishment of a national health professions data base along the lines of Section 707 of Senate Bill S.3585. Without some such data base, any approach to health manpower planning, whether by public agency or private institution, will have little or no chance of success.

August 23, 1974

Memorandum #74 - 26

To: The Assembly

From: John A.D. Cooper, M.D., President

Subject: Health manpower legislation review and outlook

This Memorandum reviews the present situation of federal health manpower legislation, provides Association reaction to the situation, and outlines current Executive Committee planning for further developments.

### Current situation

As the House and Senate today began their Labor Day recess, health manpower legislation in each chamber was undergoing final preparation for consideration on the floor. In the Senate, an unusually divided committee had approved a bill by a 10-5 vote. In the House, a similarly divided subcommittee neared the end of marking up a bill.

The general concept of each bill, and many of the specific provisions of each bill, are supported by the Association. For example, the Association recognizes the seriousness of geographic and specialty maldistribution and has developed recommendations for dealing with each problem. At the same time, the Association disagrees with some provisions of each bill and is deeply concerned by developments surrounding the capitation-grant mechanism for providing federal assistance to undergraduate medical education.

The Senate bill proposes to maintain a rate of capitation at a level slightly higher than the present level, provided that schools secure agreements of national service from all entering students and increase enrollment of undergraduates or of physician extenders. In other provisions, the bill requires national certification of housestaff positions and a system of national licensure.

The House bill proposes to drop capitation below present levels, with some capitation earmarked for certain activities, provided certain additional conditions are met. The final shape of the forthcoming bill is uncertain.

### Association Reaction

The Association developed a number of specific reactions to legislative developments as the bills moved through the legislative process. Because the Association positions still are relevant, and because there may be opportunities for you to stress the positions to your Senators and Representatives during the recess, four key positions are listed below.

#### Mandatory service (House and Senate bills)

Objections: Whether applied universally or by quota, mandatory national service requirements are in essence a doctor draft, an issue which needs much fuller debate. Association lawyers have advised that mandatory national service for only certain kinds of health professions students is of doubtful legality and constitutionality. Experience with voluntary service-commitment scholarships suggests that the personnel needs of underserved areas could be met through increased scholarship funding which would attract significant numbers of additional students.

Recommendation: Substitute a voluntary approach, using the Public Health and National Health Service Corps Scholarship program, with increased funding based on per-student support of \$10,000 annually, at present support levels.

Supporting evidence: The voluntary sector should be given every chance to meet national objectives before coercive mandatory controls are imposed. The voluntary sector has not been given an adequate opportunity to perform in meeting the manpower needs of shortage areas. There are two voluntary programs, the Public Health and National Health Service Scholarships program and the Physician Shortage Area Scholarship Program. National health service scholarships were established in 1972, and currently are supporting 345 medical students. Initial awards have just been made under the shortage area program to about 380 students. Far more students are interested in the programs. Application-to-award ratios for both programs are 3 to 1. Further increasing the applicant pool is the number of students (perhaps 2,500) who normally would require Health Professions Scholarships, which are being phased out. From these data alone, it appears that some 4,500 students per year would voluntarily be available for an expanded national health service scholarship program. If two years of service are required, some 9,000 physicians would be available for service in shortage areas.

#### Departments of Family Medicine (House bill)

Objections: Provisions mandating organizational structure of a school and its curriculum violate institutional sovereignty and are an anathema to the Association. Requiring establishment of Departments of Family Medicine is an ineffective and inefficient device for increasing Family Medicine residencies, since exposure to a particular course of study does not necessarily determine specialty choice. A mandatory provision is redundant since most schools (61) already have departments or divisions of family medicine.

Recommendation: Substitute a voluntary approach using a capitation bonus to the school for each graduate in the preceeding year who enters a family medicine residency. Provide support for residency stipends and educational and instructional costs of programs in graduate medical education designed to produce primary care physicians: family physicians, generalist-internists and generalist pediatricians.

Supporting evidence: Specific incentives for achieving directly the objective of increased numbers of family medicine, generalist-internist and generalist-pediatrician residents are more effective and efficient. There is strong evidence that incentives, working through a voluntary approach, will result in more primary care residents. In the present year, the number of graduates desiring first-year residency places in Family Medicine exceeded the number of available places by approximately 1,000. This occurred at the same time the number of first-year places increased by almost 50 percent. Of the approximately, 11,000 graduates, 1,854 applied to at least one Family Medicine program. There are increasing numbers of training programs directed at producing generalist-internists and generalist-pediatricians, rather than subspecialists. The results of studies being carried out by the Coordinating Council on Medical Education and the Institute of Medicine on residency training (which are described below) will provide additional information for developing methods to provide a better distribution of specialty training.

#### Capitation-grant support for outreach programs (House bill)

Objections: Provisions under consideration to mandate a percentage of capitation-grant support for outreach programs, such as area health education centers or WAMI (Washington, Alaska, Montana, Idaho) projects, show a misunderstanding of the relationship between capitation support and special project support. Capitation assistance is to provide a federal share of those elements of research, teaching and patient care essential to undergraduate medical education. Special project support is to meet the cost of high national priority

projects, as determined by the federal government, which a medical school is uniquely qualified to undertake. Special project support is clearly the appropriate method to stimulate development of outreach programs.

Recommendation: Substitute a voluntary approach, including as an optional condition for capitation support an approved special project application for an outreach program.

Supporting evidence: In addition to AHEC and WAMI-type projects, a number of other outreach approaches are used by medical schools. Most schools have established affiliations with community health care institutions in which undergraduate and graduate medical education and training are provided for students from the schools. The number of these affiliations has tripled during the past decade. They now average 10 affiliations per medical school. Two-thirds of the affiliations are classified as major, with strong medical school-hospital relationships. A number of community based schools depend either entirely (Michigan State) or substantially (Illinois, Indiana) on community hospitals and ambulatory care facilities for their clinical education programs. Medical schools operate health maintenance organizations and community health centers in underserved areas.

#### National certification of housestaff (Senate bill)

Objections: Provisions establishing a national commission to study housestaff requirements and ultimately to certify housestaff positions for reimbursement by federal programs are redundant, because other legislation already enacted calls for such a study. Further, a similar effort in specialty distribution is underway in the private sector, and the proposed national commission puts the federal government in the position of pre-empting work in progress in the private sector.

Recommendation: Substitute a provision that the HEW Secretary is to report to the Congress on the progress made in the private sector in determining housestaff needs and methods of modifying specialty distribution.

Supporting evidence: A 1973 Social Security bill (HR 11333 -- PL 93-233) directs the Institute of Medicine of the National Academy of Science to, among other things, conduct a study of housestaff needs and housestaff support. These are the same issues the proposed National Council on Postgraduate Physician Training is to study. In June, the Coordinating Council on Medical Education (comprised of the AAMC, AMA, AHA, CMSS, ABMS) adopted a report which called for increasing specialty training in primary care fields, not only through family medicine programs but also through programs for generalist-internists and generalist-pediatricians.

#### Association Objectives

The Association's efforts are directed at both strategic and tactical objectives.

Strategic: The Association's strategic objective continues to be development of a health manpower bill which most closely resembles the recommendations developed by the Krevans Committee and approved by the Executive Council on December 14, 1973. Among other recommendations, the AAMC policy called for capitation at a level slightly higher than the present level, with no preconditions. Capitation bonuses were to be available for increasing enrollment of undergraduates, or for programs in primary care, or for programs in underserved areas. At the heart of the Association policy was the preservation of the capitation-grant mechanism in as close to its original concept as possible. As developed and enacted in 1971, capitation-grant assistance was designed to provide substantial and continuing support for the federal share of the research, teaching and patient care activities of a medical school that were essential to undergraduate medical education. Other than routine fiscal accountability, no preconditions were to be attached.

Tactical: The Association's tactical objectives are to secure adoption of the four specific recommendations listed above and to provide House and Senate

conferees with the strongest possible position on those provisions of each bill which are acceptable to the Association. The controversial nature of some of the provisions of each bill, and the resulting divisions in the House and Senate committees, provide an unusual opportunity for further efforts to achieve Association objectives. As appropriate, these efforts may be directed at floor action in the Senate and at subcommittee, committee and floor action in the House. The nature of the effort -- an amendment, a vote, or a speech -- is perhaps best left to the individual Senator and Representative, since many factors are likely to influence their decision.

#### Executive Committee Planning

As the health manpower bills have moved through the legislative process, the original concept of the capitation-grant mechanism has become increasingly distorted. Both the House and the Senate have seized on the mechanism as a means of government intrusion into the medical educational process. The cumulative effect of the repeated intrusions has been to convert capitation from open-ended institutional support to tightly restricted project support distributed on a per capita basis. The Association's Executive Committee has become extremely disturbed at these developments.

The Association's Executive Committee is deeply enough concerned with the changing nature of capitation assistance to undertake a search for alternate mechanisms for channeling federal assistance to undergraduate medical education. While no decision on selecting a new mechanism has been made, such a decision would represent a major change in fundamental Association policy. The Executive Council may call for a special meeting of the Council of Deans and representatives of the other Councils, if further legislative developments determine that such action is necessary.

In reconsidering the Association's health manpower policy, one alternate approach which could be considered would call for decreasing reliance on capitation-grant funds and increasing reliance on tuition, state appropriations and other sources of income. Capitation would be gradually phased out, thus permitting schools to develop alternate sources of support over a period of three years. This approach would substitute for the present programs of capitation and student assistance a new program of expanded student assistance. It would be comprised of National Health Service Corps scholarships and of loans with an option of forgiveness for service. Each component of the new program would provide funds for tuition and fees up to a certain level plus a cost-of-living stipend. The HEW Secretary would be able to pay directly to a school the tuition-and-fee portion of the aid. It would be assumed that the indebtedness of students under the loan program would be substantial enough that virtually every student would exercise the forgiveness option. Thus national service would be provided by all scholarship recipients and by nearly all loan recipients. It is further assumed that schools, in order to offset the loss of capitation-grant income, would increase tuition, unless they were able to offset the loss of capitation with state appropriations or other funds.

The intent of such a new approach would not be to increase the amount of federal funds flowing to the medical school. In fact, the amount is likely to be about the same as under a capitation program. Instead, the intent would be to curb the federal intrusion into the medical education process.

CAS-COD-COTE JOINT MEETING

AAMC ANNUAL MEETING  
Wednesday, November 13, 1974  
2:00 - 5:15 P.M.

SPECIALTY DISTRIBUTION OF PHYSICIANS

2:00 - 2:30 P.M.     *A Congressional Perception of the Problem*

Mr. Stephen E. Lawton  
Counsel for the Subcommittee on  
Public Health & Environment  
of the House Interstate and  
Foreign Commerce Committee

2:30 - 3:00 P.M.     *Redistribution of Specialty Training  
Opportunities - Options for the Private  
Sector*

Arnold S. Relman, M.D.  
Chairman, Department of Medicine  
University of Pennsylvania  
School of Medicine

3:00 - 3:30 P.M.     *Redistribution of Specialty Training  
Opportunities - Options for the Government*

Theodore Cooper, M.D.  
Deputy Assistant Secretary for Health  
Department of Health, Education and  
Welfare

3:30 - 3:50 P.M.     Intermission

3:50 - 5:15 P.M.     Panel Discussion

*The panel discussion will take the form  
of a question and answer session during  
which the following three individuals  
will direct questions to the above  
speakers.*

Chairman:     Julius R. Krevans, M.D., Dean  
University of California, San Francisco  
School of Medicine

Robert A. Chase, M.D., Chairman  
Department of Anatomy  
Stanford University School of Medicine

Charles B. Womer, Director  
Yale-New Haven Hospital

1 *not be further delegated to any officer in any regional office*  
2 *or offices."*

3 *"RECORDS AND AUDIT*

4 *"SEC. 706. (a) Each recipient of financial assistance*  
5 *(including each entity which receives a grant, loan, loan*  
6 *guarantee or interest subsidy or which enters into a contract*  
7 *with the Secretary) under this title shall keep such records*  
8 *as the Secretary shall prescribe, including records which*  
9 *fully disclose the amount and disposition by such recipient of*  
10 *the proceeds of such financial assistance, the total cost of the*  
11 *project or undertaking in connection with which such finan-*  
12 *cial assistance was given or used, and the amount of that*  
13 *portion of the cost of the project or undertaking supplied by*  
14 *other sources, and such other records as will facilitate an*  
15 *effective audit.*

16 *"(b) The Secretary and the Comptroller General of the*  
17 *United States, or any of their duly authorized representa-*  
18 *tives shall have access for the purpose of audit and exami-*  
19 *nation to any book, document, papers, and records of such*  
20 *recipients that are pertinent to the financial assistance re-*  
21 *ceived under this title."*

22 *"NATIONAL HEALTH PROFESSIONS PERSONNEL DATA BASE*

23 *"SEC. 707. (a) The Secretary shall establish a health*  
24 *professions personnel data base which shall include data*  
25 *respecting all physicians, dentists, pharmacists, optometrists,*

1 podiatrists, veterinarians, public health personnel, health care  
 2 administration personnel, audiologists speech pathologists,  
 3 chiropractors, nurses, physician extenders (including nurse  
 4 practitioners) and allied health personnel in the United  
 5 States and its territories and such other health personnel as  
 6 the Secretary deems appropriate. Such data base shall in-  
 7 clude, but not be limited to, information respecting the  
 8 training, licensure status (including permanent, temporary,  
 9 partial, limited, or institutional), place or places of practice  
 10 and hours of practice spent in each such place, hospital  
 11 affiliations, place and date of birth, sex, and such other  
 12 descriptive and demographic information regarding health  
 13 professions personnel as the Secretary shall prescribe.

14       “(b)(1) The Secretary shall collect the available in-  
 15 formation described in subsection (a) from appropriate State  
 16 and Federal agencies and other appropriate sources.

17       “(2) The Secretary shall conduct or enter into con-  
 18 tracts for the conduct of analytic and descriptive studies of  
 19 health professions personnel, including, but not limited to,  
 20 evaluations and projections of the supply, specialty, and  
 21 geographic distribution, and quality of services delivered  
 22 by health professions personnel.

23       “(c)(1) The Secretary is authorized to make grants to  
 24 States for the purpose of establishing a uniform health pro-  
 25 fessions personnel reporting system. The Secretary shall deter-

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1 mine the amount of any grant but no grant shall exceed  
2 \$100,000 and no State shall receive more than one grant.

3       “(2) To be eligible for a grant under this subsection a  
4 State shall submit an application, in such form and manner  
5 and containing such information as the Secretary shall re-  
6 quire. Such application shall include reasonable assurances,  
7 satisfactory to the Secretary, that (A) such State will estab-  
8 lish a program of mandatory annual registration of the health  
9 professions personnel described in subsection (a) who reside  
10 of practice in such State and of health institutions licensed  
11 by such State, which registration shall include such informa-  
12 tion as the Secretary shall prescribe, specifically including  
13 data regarding graduates of medical schools located in for-  
14 eign countries, and (B) such State shall collect such infor-  
15 mation and report it to the Secretary in such form and  
16 manner as the Secretary shall prescribe.

17       “(d) For purposes of providing the Secretary with  
18 information described in subsection (a), each school which  
19 receives financial support under section 770 shall report to  
20 the Secretary annually information respecting the students  
21 which attend such institution and their postgraduation  
22 career plans (if available).

23       “(e) (1) The Secretary shall provide technical assistance  
24 to the States and political subdivisions thereof in the develop-  
25 ment of model laws concerning confidentiality and compara-  
26 bility of data collected pursuant to this section.

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1       “(2) Subject to applicable law regarding confidentiality,  
2 the data collected by the Secretary under this section shall be  
3 made available to bona fide researchers and analysts for the  
4 purpose of conducting studies respecting health professions  
5 personnel.

6       “(f) The Secretary shall assemble and submit to the  
7 President and to Congress not later than September 1 of each  
8 year a report on the status of health professions personnel in  
9 the United States, which report shall include a description  
10 and analysis of the data collected pursuant to this section.

11       “(g) There are authorized to be appropriated such  
12 sums as may be necessary to carry out the purposes of this  
13 section.”

14       “(g) If, within twenty years (or ten years in the case of a  
15 facility constructed with funds paid under part A as in effect  
16 before the date of the enactment of the Health Professions  
17 Educational Assistance Act of 1974) after completion of the  
18 construction of any facility for which funds have been paid  
19 under such part A (as so in effect) or under part D (as in  
20 effect before July 1, 1967)—

21               (1) the applicant for such funds or other owner of  
22 such facility shall cease to be a public or nonprofit private  
23 entity, or

24               (2) such facility shall cease to be used for the pur-  
25 poses for which such funds for its construction were pro-

1 vided, unless the Secretary determines, in accordance  
 2 with regulations, that there is good cause for releasing  
 3 the applicant or other owner from the obligation to do so,  
 4 the United States shall be entitled to recover from the appli-  
 5 cant or other owner of the facility the amount bearing the  
 6 same ratio to the then value (as determined by agreement of  
 7 the parties or by action brought in the United States district  
 8 court for the district in which such facility is situated) of the  
 9 facility, as the amount of the Federal participation bore to  
 10 the cost of construction of such facility.

11 (h) The Secretary of Health, Education, and Welfare  
 12 shall submit an evaluation report to the Committee on Labor  
 13 and Public Welfare of the Senate and the Committee on  
 14 Interstate and Foreign Commerce of the House of Repre-  
 15 sentatives not later than March 31 of each year. Such report  
 16 shall—

17 (1) contain the Department's statement of specific  
 18 and detailed objectives for the program or programs  
 19 assisted under the provisions of this Act, and relate these  
 20 objectives to those in this Act,

21 (2) include statements of the Department's conclu-  
 22 sions as to effectiveness of the program or programs in  
 23 meeting the stated objectives, measured through the end  
 24 of the preceding fiscal year,

25 (3) make recommendations with respect to any

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changes or additional legislative action deemed necessary or desirable in carrying out the program or programs,

(4) contain a listing identifying the principle analyses and studies supporting the major conclusions and recommendations, and

(5) contain the Department's annual evaluation plan for the program or programs through the fiscal year for which the budget was transmitted to Congress by the President, in accordance with section 201(a) of the Budget and Accounting Act, 1921, as amended (31 U.S.C. 11).

(i) The heading for part A of title VII is amended to read as follows:

**"PART A—GENERAL PROVISIONS".**

(j) The heading for part H of title VII is repealed.

**TITLE II—ASSISTANCE FOR CONSTRUCTION OF TEACHING FACILITIES**

**SEC. 201.** Section 720 is amended to read as follows:

**"GRANT AUTHORITY; AUTHORIZATIONS OF APPROPRIATIONS**

**"SEC. 720. (a)** The Secretary may make grants to assist in the construction of teaching facilities for the training of physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.

**"(b)** There are authorized to be appropriated \$100,-

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