



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

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 14-15, 1975

January 14, 1975

6:30 p.m.	Cocktails	Plaza Room
7:30 p.m.	Dinner	Dupont Plaza Hotel

January 15, 1975

8:30 a.m.	Administrative Board Business Meeting (Coffee and Danish)	Room 827 One Dupont Circle
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon and General Session	Dupont Room Dupont Plaza Hotel
	Health Manpower Discussion	
4:00 p.m.	Adjourn	

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 15, 1975

- I. REPORT OF THE CHAIRMAN
- II. ACTION ITEMS
1. Approval of Minutes of CAS Administrative Board Meeting of September 19, 1974 1
 2. All action items in the accompanying Executive Council Agenda
- III. DISCUSSION ITEMS - (Action may be taken on these items at the pleasure of the Board)
1. CAS policy regarding CAS Administrative Board Members who become Deans 6
 2. Consideration of policy on how new specialties should be designated and new specialty boards approved 7
 3. Consideration of resolution from the Society of Academic Anesthesia Chairmen 10
 4. Reconsideration of NBME Institutional Rankings 11
- IV. QUALITY OF MEDICAL EDUCATION
- "*The Role of Research in Medical Education*" - Resolution from The Association of Chairmen of Departments of Physiology 12
- V. INFORMATION ITEMS
1. Letter from American Academy of Family Physicians declining invitation to meet with CAS Administrative Board 14
 2. Executive Council Task Force on NBME GAP Report with modifications recommended by CAS and OSR 15
 3. Modification of membership on the NBME 15
 4. Report of the AAMC Officers' Retreat 16
 5. Status Report on NRC/NAS Feasibility Study of Biomedical Research Manpower Monitoring - (to be reported if information available)

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

September 19, 1974

AAMC Headquarters
Washington, D.C.

PRESENT:	<u>Board Members</u>	<u>Staff</u>
	Ronald W. Estabrook, Chairman (Presiding)	Michael F. Ball
	Robert M. Blizzard	William G. Cooper
	David R. Challoner	Mary H. Littlemeyer
	D. Kay Clawson	Emanuel Suter
	Carmine D. Clemente	August G. Swanson
	Rolla B. Hill, Jr.	
	Leslie T. Webster	

ABSENT: Board Members

- A. Jay Bollet
- *Ernst Knobil
- *Robert G. Petersdorf

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting held June 20, 1974, were adopted as circulated.

II. Format of Meeting

The format of the meeting was revised to permit a joint meeting of the Administrative Boards of the three AAMC Councils, which convened at 1:00 p.m. with a luncheon at the Dupont Plaza Hotel and continued through the afternoon.

III. Action Items

A. Membership Dues

ACTION: A motion that the Association of Teachers of Preventive Medicine pay the assessed CAS membership dues was unanimously approved.

* Ex Officio

B. Special Meeting

ACTION: Staff were authorized to organize a meeting of the Council of Academic Societies Administrative Board with the American Academy of Family Physicians Executive Committee and representatives of the Society of Teachers of Family Medicine. The meeting will be the evening of January 14, immediately preceding the next scheduled CAS Board meeting.

C. Proposed HPEA Legislation

ACTION: The CAS Administrative Board voted unanimously to recommend that the AAMC be advised of the faculty's concern about the portions of the proposed HPEA bill that constrain and impinge upon the integrity of undergraduate and graduate medical education even to recommend the defeat of the total bill. The CAS Administrative Board further recommends that every Dean and every Board of Trustees seek every opportunity to obtain funding through alternative means such as tuition increases, increased support from state legislatures, or a decrease in faculty size where necessary to preserve the role of the medical schools in developing and implementing educational programs.

D. LCME Accreditation Decisions

ACTION: The CAS Administrative Board voted unanimously to ratify the LCME accreditation decisions as set forth in the Executive Council Agenda on pages 24-26.

E. AAMC Policy Statement

ACTION: The CAS voted to approve the revised AAMC Policy Statement on New Research Institutes and Targeted Research Programs as set forth in the Executive Council Agenda on pages 36-37. One vote was cast against the motion.

F. Student Representation

ACTION: The CAS Administrative Board considered the request by the OSR Administrative Board for student participation and representation in the CCME and in the LCME in the Executive Council Agenda on page 38. The CAS Administrative Board voted unanimously to accept the student's request to sit on the CCME with the recommendation that such individual serve for no less than two years. Due to the operational nature of the LCME activities, however, it was felt inappropriate to create a student seat on the LCME.

G. GME Resolution on NBME Rankings

ACTION: The CAS Administrative Board voted to defeat the GME Resolution on NBME Rankings as set forth in the Executive Council Agenda on page 39. One vote was cast against the motion.

H. COTH Membership Criteria

ACTION: The CAS Administrative Board voted unanimously to approve the Report of the COTH Ad Hoc Committee on COTH Membership Criteria as set forth in the Executive Council Agenda on pages 40-49.

I. JCAH Standards

ACTION: The CAS Administrative Board voted unanimously to approve the Report of the COTH Ad Hoc Committee on JCAH standards as set forth in the Executive Council Agenda on pages 53-73.

J. Physician Manpower & Distribution

ACTION: The CAS Administrative Board unanimously endorsed the CCME Report on Physician Manpower and Distribution with thanks to the Committee.

K. Violations of NIRMP

ACTION: The CAS Administrative Board unanimously approved a recommendation to the Executive Council that it direct the LCGME, after appropriate review, to take punitive action in cases of recognized violations of NIRMP.

L. Physician Manpower Distribution

ACTION: The CAS Administrative Board unanimously approved the following recommendations from the Health Services Advisory Committee:

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.

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.

IV. Discussion Items

A. American Professors Teaching in Mexican Medical Schools

Dr. Suter discussed the situation whereby U.S. medical school faculty are donating teaching time at the Guadalajara Autonomous University with only their travel and living expenses paid. Although concern was expressed that this might foster a further erosion of the educational system, it was felt that faculty should be able to spend their free time as they see fit. It was recommended that this topic be put upon the agenda for the November meeting of the full Council.

B. Executive Council Resignations

The Board noted with regret the resignations from the Executive Council of Drs. William Mayer and William Maloney each of whom had left his post as dean.

C. Election of New Members

The Board noted without action the names of those proposed for membership in the AAMC.

D. Borden Award

The Board discussed the paucity of names of outstanding scientists submitted for the 1974 Borden Award and the suggestion of Dr. Robert Berne that a better mechanism be sought for obtaining nominations. The Board indicated its willingness to seek one

nomination from every CAS member society if the Executive Council would wish to pursue this approach.

E. Retreat Agenda

Dr. Swanson explained that the Association is publishing a book that contains a description of AAMC's programs and policies in various areas. This book will be distributed to the constituents and will be updated. The purpose of the retreat is to establish priorities among the AAMC programs and the issues that will confront medicine in the next five years.

F. Biomedical Research Committee

The problems encountered in maintaining any momentum with this committee were reviewed by Dr. Ball. Long-range goals must be defined, and a strong chairman and committee members who have the sense of priority and commitment to realize the goals must be found. Since Dr. Ball's resignation will be effective November 1, he has not pursued this.

V. Information Items

A. The CAS Administrative Board received the Report of the CAS Nominating Committee as set forth in the agenda on page 24.

B. The CAS Administrative Board reviewed the calendar of activities for the AAMC Annual Meeting.

VI. Adjournment

The meeting was adjourned at 12:50 p.m.

MHL:kb
12/2/74

CAS POLICY REGARDING CAS ADMINISTRATIVE BOARD MEMBERS
WHO BECOME DEANS

In the reorganization of the Association, the Council of Academic Societies was created as a Council to represent the views of faculty. This year, for the first time, the Administrative Board is faced with the problem of having two of its elected members become deans. There are no provisions in the Rules and Regulations enunciating a policy regarding whether officers of the CAS who become deans should continue as officers or should resign. There are also no provisions in the Rules and Regulations for replacement of officers who have resigned during the interim period between Council meetings.

In the Council of Deans when an individual resigns as dean of an institutional member, he also resigns from the Council and from any office he may hold in the Association. This is a legal necessity because individuals may not hold offices in the Association as individuals. All officers, and all members voting in the Assembly, must represent institutions or societies.

As long as the individuals who are officers of CAS continue to be representatives of their societies, there is no legal necessity for them to resign, even though they become deans. Therefore, the question of whether an Administrative Board member who has become a dean should resign is a matter for policy decision. Members of the Council of Deans are defined as "the Dean or the equivalent academic officer of each institutional member". Thus, if CAS Administrative Board members who have become deans remain on the Board, they would also hold voting membership in the Council of Deans and could also be elected to the Administrative Board of the Council of Deans. This would appear to be a conflict-of-interest within the governance structure of the Association.

Should the decision be made that these members of the Administrative Board should resign, it will not be possible to replace them until the next regular election at the Annual Meeting of the Council. Consideration should be given to changing the Rules and Regulations to provide for the replacement of Administrative Board members who resign.

CONSIDERATION OF POLICY ON HOW NEW SPECIALTIES SHOULD BE DESIGNATED
AND NEW SPECIALTY BOARDS APPROVED

The designation of new specialties and the approval of new specialty boards has, in the past, rested with the AMA and the American Board of Medical Specialties. There is a Liaison Committee on Specialty Boards with equal representation from the ABMS and the Council on Medical Education of the AMA. Recommendations of this Liaison Committee must be approved by both the ABMS and the House of Delegates of the AMA before a new specialty can be designated and a board created. At present there is a movement to create a Board for Emergency Medicine. The accompanying letter from Jack Nunemaker to the ABMS Membership provides some information regarding the status of negotiation for this board.

The question now has been raised regarding whether the Coordinating Council on Medical Education and its parent organizations should be involved in the decision to designate a new specialty and create a specialty board. Although the Coordinating Council has been in existence for two years, the Council on Medical Education and the ABMS have unilaterally conducted negotiations for the creation of the new Board of Emergency Medicine. Logically, the CCME should be the agency which sanctions the creation of new boards because the CCME has jurisdiction over graduate education as well as undergraduate education in medicine, and must develop policies for the accreditation of all programs in all specialties. A committee has been created, made up of members of the CCME and the LCGME, to consider this question. Guidance from the Administrative Board is needed regarding whether the Association should press for involvement of the CCME. Because the designation of new specialties and the creation of new boards inevitably has major impact upon our academic institutions, it would appear advantageous for the Association to have a voice in decisions in this area through the Coordinating Council.

AMERICAN BOARD OF MEDICAL SPECIALTIES

JOHN C. NUNEMAKER, M.D.
Executive Director

DAVID E. SMITH, M.D.
Associate Director



1603 Orrington Avenue, Suite 1160
Evanston, Illinois 60201
(312) 491-9091

December 12, 1974

MEMORANDUM

TO: Secretary of Each Member Board
Executive Officer of Each Associate Member

FROM: Executive Director, ABMS

SUBJECT: Emergency Medicine *DS*

ACTION: For your information

This is a progress report on contacts of Central Office staff regarding certification in Emergency Medicine.

On Sunday, December 1, Dr. Smith and Dr. Nunemaker were asked to meet with representatives of the American College of Emergency Physicians during the AMA meeting in Portland. The purpose of this meeting was to discuss briefly the procedures involved in application for a new specialty board.

It was noted that there had been a meeting on November 16, 1974 of an Ad Hoc Committee on Standards for Graduate Medical Education in Emergency Medicine under the Chairmanship of Dr. Vernon Wilson, Chairman of the Council on Medical Education's Committee on Emergency Medicine. New specialty boards were not discussed at that Conference, however.

It was also indicated that contact had been made with the National Board of Medical Examiners regarding preparation of an examination for qualification in Emergency Medicine which might have future application to a certification examination.

There was further discussion of the Essentials for Approval of Examining Boards in Medical Specialties and the role played by the Liaison Committee for Specialty Boards in the administration of requests for approval of new Boards. ABMS staff indicated that any group petitioning for a new Board carried the responsibility of developing all necessary liaison with every other specialty group which might be concerned with education and/or certification in the particular field being considered for specialty certification.

In the course of the discussion, some representatives were familiar with the history of the procedures leading to approval of the American Board of Family Practice. It was noted that one of the important elements in this

Emergency Medicine
December 12, 1974

approval was inclusion of representatives of five other primary boards on the American Board of Family Practice. The question was raised as to whether this arrangement for participation of other primary boards was projected for only limited application in terms of time. No such arrangement was included in the consideration of the Liaison Committee for Specialty Boards, and this has recently been confirmed with officials of the American Board of Family Practice.

It was also noted that the American College of Emergency Physicians was not concerned with certification in Critical Care Medicine, but was concerned with establishment of a primary board in Emergency Medical Care.

The point of this memorandum is to advise ABMS member organizations that plans are being made for application for approval of a new Board at some appropriate time in the future, and that representatives of a variety of specialty organizations may be contacted by representatives of the American College of Emergency Physicians and/or the University Association for Emergency Medical Services for support in this endeavor.

THE NEW PHYSICIAN for December 1974 carries an illuminating article on Emergency Medicine and the goals of the groups mentioned in this memorandum.

JCN:ce

CONSIDERATION OF RESOLUTION FROM THE SOCIETY OF ACADEMIC ANESTHESIA CHAIRMEN

Late in the Annual Meeting of the Council, a resolution was introduced from the Society of Academic Anesthesia Chairmen and referred to the CAS Administrative Board. This resolution requests that the Council of Academic Societies acknowledge the critical shortage of academic anesthesiologists and strongly support efforts to rectify this deficiency in specialty distribution of physicians.

It should be noted that the resolution speaks specifically to a shortage of academic anesthesiologists. Training and retaining specialists as faculty in academic medicine may or may not be related to the overall supply of specialists in any single field. Data from the National Center for Health Statistics on anesthesiology are as follows: In 1970, there were 10,860 anesthesiologists making up 3.5% of the total number of active physicians. The projection for 1980 is a total of 17,360 anesthesiologists making up 4% of active physicians. These data presume a continued influx of foreign medical graduates at the present rate.

The Administrative Board must consider whether it believes the Association should become involved in analyses of why one or another specialty has difficulty in retaining sufficient faculty.

RESOLUTION

WHEREAS, the membership of the Society of Academic Anesthesia Chairmen has affirmed that in a university medical center sufficient faculty positions be allocated to provide effective supervision and direction of medical students, postdoctoral trainees and non-physician personnel that assures optimal anesthesia care and teaching and

WHEREAS, this body has agreed that all faculty members in academic anesthesiology should be provided ample time free of clinical responsibilities to pursue productive scholarly activities and

WHEREAS, adequate faculty personnel should be allocated for research, administration, obstetrical anesthesia, respiratory therapy, intensive care service, pain therapy, demanding call duty, and the personal administration of anesthesia in order to maintain their clinical skills, and

WHEREAS, less than 25% of our university medical centers have sufficient anesthesia faculty to fulfill these obligations adequately,

THEREFORE BE IT RESOLVED, that the Council of Academic Societies acknowledge the critical shortage of academic anesthesiologists and strongly support efforts to rectify this deficiency in specialty distribution of physicians.

RECONSIDERATION OF NBME INSTITUTIONAL RANKINGS

At the Executive Council Meeting in September, the Group on Medical Education requested action on a recommendation that the National Board be asked to cease ranking medical schools as regards how their students perform on Parts I and II of the National Board. This recommendation was not accepted by the Executive Council.

Subsequently, Rolla Hill has been informed that the Board of Trustees of the State University of New York has requested a report from the Deans of the several medical schools in the SUNY system regarding the National Board scores of students in each school. This implies that rankings and scores will be used as a method of determining the schools' accountability to the State University. With this possibility of utilization of National Board scores and school rankings by agencies external to the school, does the Administrative Board wish to reconsider its position on the issue of NBME rankings?

QUALITY OF MEDICAL EDUCATION

"The Role of Research in Medical Education"

The Chairman of the Council has recommended that the CAS Administrative Board consider a subject related to the quality of medical education at each of its meetings this year. The Association of Chairmen of Departments of Physiology has forwarded to the Council the accompanying resolution. This resolution will be the basis for a discussion of the quality of medical education at this meeting of the Board.

Association of Chairmen of Departments of Physiology

The Role of Research in Medical School Accreditation

"...if the United States is to have a system of medical education capable of producing physicians able to render acceptable care to patients, every medical school must maintain a research program for the learning of its teachers and students. The alternative is to have teaching in some medical schools twenty-five years out of date and physicians graduating with the knowledge and skill of the previous generation. The consequence of this would be to widen the range of physician competence, lower the minimum level of permissible competence, and encourage the present inadequate medical care that many of our citizens now receive. I therefore recommend a research policy which expects and demands a minimum research activity in every medical school."

This view, expressed by John S. Millis in his recent report to the National Fund for Medical Education, is widely shared by medical educators and embraced by some of the most trenchant critics of contemporary medical education. The Carnegie Commission on Higher Education, for example, states in its report on Higher Education and the Nation's Health that "...every [university health science] center needs a research program to fulfill its educational function..."

The document entitled "Functions and Structure of a Medical School", an official statement by the Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association identifies the advancement of knowledge through research as one of four "inherent responsibilities" of a medical school.

Yet, in the process of accrediting medical schools, the research programs of these institutions are not often considered in a more than perfunctory manner. Some accredited medical schools do not have significant research programs, and some developing medical schools are establishing their educational programs in the absence of clear commitments to investigative activity.

The seeming discrepancy between the foregoing and the relative disdain of a school's research enterprise in the accreditation process has been, and continues to be, a grave concern to the Association of Chairmen of Departments of Physiology, a component of the Council of Academic Societies of the Association of American Medical Colleges. It addresses this concern by offering the following resolution:

"WHEREAS, it is widely agreed that the conduct of biomedical research, both basic and applied, is an important function of a medical school and that exposure to such an activity and biomedical researchers is a vital part of the education of physicians, BE IT RESOLVED,

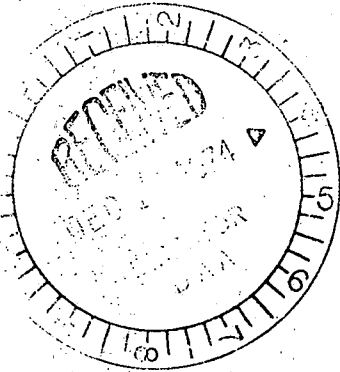
That the evaluation of medical schools for purposes of accreditation include an identifiable component which addresses itself to the quantity and quality of biomedical research and that the AAMC ensures that all accreditation survey teams include at least one recognized investigator in the biomedical sciences".

AMERICAN ACADEMY OF FAMILY PHYSICIANS

1740 WEST 92ND STREET

KANSAS CITY, MISSOURI 64114

ROGER TUSKEN
EXECUTIVE DIRECTOR



December 13, 1974

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

Dear Gus:

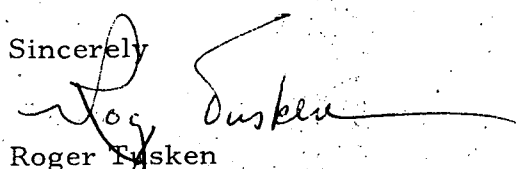
Please forgive the delay in responding to your letter of October 30, which was considered by our Board of Directors at a recent meeting.

The Board was appreciative of your suggestion that our Executive Committee meet with the Council of Academic Societies in Washington on January 14. Unfortunately, our Executive Committee cannot be in Washington at that time so we must regretfully decline.

As you know, our Executive Committee members were guests of the AAMC Executive Committee at a dinner meeting on June 21, 1973. This was a most productive conference from our standpoint and since that time we have been trying to arrange another meeting when we could host the AAMC Executive Committee. Our Board is of the opinion that such a meeting would be mutually beneficial to the governing bodies of our two organizations.

We continue to look forward to a favorable response to our invitation and a suggestion for a time and place of a meeting between our Executive Committees.

Sincerely


Roger Tusken

rt: hc: jr

cc: AAFP Executive Committee
John A.D. Cooper, M.D.

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EXECUTIVE COUNCIL TASK FORCE ON NBME GAP REPORT
WITH MODIFICATIONS RECOMMENDED BY CAS AND OSR

The Task Force Report is in the Executive Council Agenda for information only at this meeting. It will be considered for action at the April meeting of the Board.

MODIFICATION OF MEMBERSHIP ON THE NBME

The National Board of Medical Examiners has recently modified its by-laws to provide for a change in membership. Through this change, the Association representation to the National Board was reduced by one position. A comparison of the old and new membership is included in the Executive Council Agenda

REPORT OF THE AAMC OFFICERS' RETREAT

December 11-13, 1974

Officers Present:

Dr. Sherman M. Mellinkoff (Chairman)
Dr. John A.D. Cooper (President)
Dr. John F. Sherman (Vice-President)
Dr. Ivan L. Bennett, Jr. (Chairman, COD)
Dr. John A. Gronvall (Chairman-Elect, COD)
Dr. Jack W. Cole (Chairman, CAS)
Dr. Rolla B. Hill (Chairman-Elect, CAS)
Mr. Sidney Lewine (Chairman, COTH)
Mr. Charles B. Womer (Chairman-Elect, COTH)
Mr. Mark Cannon (Chairperson, OSR)
Dr. Cynthia B. Johnson (Vice-Chairperson, OSR)
Dr. Kenneth R. Crispell (Distinguished Service Member)

Staff Present:

Mr. Charles Fentress
Dr. H. Paul Jolly
Dr. Richard Knapp
Dr. Emanuel Suter
Dr. August Swanson
Mr. J. Trevor Thomas
Mr. Bart Waldman
Dr. Marjorie Wilson

The retreat of the Association's officers was held December 11-13 at the Belmont Conference Center, Elkridge, Maryland. Individuals invited to attend included the Chairman and Chairman-Elect of the Association and of each Council, the OSR Chairperson and Vice Chairperson, the "coordinator" of the Distinguished Service Members, and the Executive Staff.

The discussion and recommendations of the retreat participants are presented below in the outline format in which each issue was considered.

I. AAMC Organization and Governance

A. COTH Membership Criteria

Membership criteria proposed by a COTH task force had been presented to the Executive Council and referred back to the COTH Administrative Board to provide for the inclusion of affiliated community hospitals having only a family practice residency. COTH representatives felt that a strong commitment to medical education must be shown by a hospital in order to qualify for COTH membership. The view was expressed that the nomination of an affiliated hospital by a dean might be considered to be sufficient evidence of this commitment. The issue of COTH size was also considered, since it was agreed that COTH should never try to include the over 1500 hospitals having graduate training programs and since some deans had previously expressed the view that COTH had grown too large. It was agreed that hospitals having a significant commitment to medical education should not be excluded and that a new task force which would include deans should be appointed to review the mechanics of accomplishing this.

B. Housestaff Representation

The question of including housestaff representation in the Association was discussed by the retreat participants. The OSR had suggested this item, expressing the belief that house officers should have a voice in Association affairs. A number of alternate methods by which house officers could be included in the Association, either as a governing organization such as the OSR, or in a less formal status, were presented.

Since no formal request had been presented to the Association by any group representing house officers and since a representative of the Physicians National Housestaff Association had expressed some opposition to the idea, the retreat participants felt that no action should be taken at this time. They specifically indicated that the AAMC should avoid, at all costs, giving recognition to any group which might function as a union. In discussing further alternatives, it was emphasized that if residents were to be included, the Association should seek only to represent them as teachers and students. Employee interests of house officers should never be served through the AAMC.

Doctor Bennett expressed the strong feeling that the Association should observe the housestaff situation, waiting until employee issues, which dominate the house officers' interests, calm down. He also felt that the AMA/housestaff relations should be observed for a period of time.

The retreat participants agreed that formal housestaff representation should be postponed, but that the Association should seek qualified housestaff input to appropriate committees and explore the possibility of having the deans or program directors invite house officers to the annual meeting.

C. Report of the Task Force on Groups

A task force of the Executive Council had been appointed to consider the appropriate role of the five existing groups within the AAMC, the most desirable relationship of the groups to the staff and to the Councils, and the appropriate level of staff and financial resources which should be devoted to supporting groups. The task force's report supported the existing organizational structure and allocation of resources. It went on to recommend a formal mechanism by which groups could recommend items to be considered by the Executive Council and the constituent Councils.

The retreat participants expressed their full support for the recommendations of the task force and agreed that the task force report should be circulated immediately to the group chairmen with invitations to the January meeting of the Executive Council.

D. Distinguished Service Members

Doctors Mellinkoff and Crispell discussed the first meeting of the Association's Distinguished Service Members which had been held at the annual meeting in November. The minutes of this meeting were distributed for information.

The retreat participants felt that the role which had been identified by the Distinguished Service Members was appropriate and should be pursued with enthusiasm. It was also agreed that some limit on the size of this group be sought in discussions with the Councils which recommend their election. It was also felt that editorials for the Journal of Medical Education should be sought from members of this group.

II. Relationships with Other Organizations

A. CCME, LCME and LCGME

The retreat participants discussed the general structure and function of these three bodies and then addressed specific issues raised in the retreat agenda. It was agreed that Dr. Cooper should be appointed as an AAMC representative to the CCME. It was also felt that expansion of the LCME membership, beyond the current AMA-AAMC composition, should be addressed on the merits of participation by other organizations and should not be handled as a political question. Strong feelings were expressed that at least one, and maybe all of the additional groups being proposed, should not be added on the merits of their contributions to the accreditation of undergraduate medical education.

The question of staffing the CCME was discussed but it was felt to be an issue which should not be confronted until some problem arose regarding the staffing by the AMA. It was also felt that the question of which policies should be forwarded to the CCME and which policies should be considered independently by the AAMC should be addressed on an individual issue-by-issue basis.

B. Association for Academic Health Centers and Federation of Associations of Schools of the Health Professions

Relationships with groups representing schools of other health professions were reviewed. It was agreed that the Association's close liaison with the AAHC should be continued as in the past. Special relationships with groups representing dentistry, nursing and public health were strongly supported. It was felt that the Federation should only serve as a forum for discussion and should not be used to advance positions on national legislation.

III. Staff Activities

A. Resource Allocation

Doctor Sherman reviewed in detail the process by which the staff was attempting to identify component activities and assign dollar allocations on an actual time and dollars spent basis. He outlined the methodology for this process which included the establishment of a Program and Budget Review Committee and would eventually include a system of evaluation of each of the component staff activities. The retreat participants were presented with an array of 148 distinct activities, along with a description of each and the number of person years devoted to each. Doctor Sherman also presented the dollar allocations devoted to four of the aggregate categories of activities, as well as an array of the percentage of Association manpower being assigned to each general classification.

The retreat participants supported the concept of the program budgeting and expressed the view that this activity would be more useful as an internal educational tool than for any other purpose. It was stressed that the figures would never be accurate and should not be relied on too heavily. Mr. Lewine indicated that if the figures were within ten percent of the actual numbers, the Association would be doing well. He also expressed a strong feeling that any attempt to determine priorities through a mechanism of program assessment would be futile.

The mechanics of the study were reviewed and the feeling expressed that the personnel figures presented needed to reflect dollar expenditures and not simply person years. The treatment of Federal Liaison activities by including them in the substantive areas was supported.

Doctor Bennett reminded the retreat that priorities must also be looked at in terms of which activity, when reduced, will save the most dollars. This meant that a decision to cut back an activity would be meaningless unless the number of people and/or the travel funds could be reduced.

It was agreed that the January Executive Council meeting would be presented with the process being undertaken. Representatives of each Council would be asked to assess the expectations of the Council members regarding this display and its ultimate effect on the setting of priorities. The retreat participants also discussed inconclusively the concept of asking a management consultant to work with the Association on this activity.

B. Space Requirements

Doctor Cooper and Mr. Thomas discussed the activities of the Building Committee, the expanded space requirements of the Association, and the Washington, D.C. real estate market. The Building Committee had recommended that the staff actively seek either the outright purchase of an existing facility or the leasing, with option to buy, of office space where the staff activities could be consolidated. Mr. Thomas indicated that market conditions in the Washington area were extremely unfavorable to this type of action. It was recommended that the AAMC continue to lease space at One Dupont Circle and elsewhere as needed. More favorable market conditions are anticipated within two to three years.

The retreat participants concurred in this recommendation, adding that it would be psychologically disadvantageous to purchase office space at a time when general economic conditions affecting the constituency were so restricting.

IV. Physician Production and Distribution

A. Federal Support of Medical Education

The retreat participants reviewed the steps which had been taken since the meeting of the Assembly to reconsider the Association's position on health manpower legislation. They agreed with the appointment of a Task Force on Health Manpower, chaired by Dr. Daniel Tosteson, and reviewed the questionnaire which had been sent to the full AAMC membership. It was felt that the substantive consideration of health manpower policies should be left to the task force with recommendations to come before the Executive Council.

In anticipation of the task force report, it was recommended that meetings be arranged with potentially influential individuals. The discussion then turned to suggestions of people who would be appropriate contacts with House and Senate leaders. It was also suggested that deans and hospital directors be encouraged to visit nearby, underserved areas to establish the basis for future outreach programs.

B. Output and Adequacy

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RESULTS OF THE HEALTH MANPOWER QUESTIONNAIRE

	COTH- (171)		CAS- (129)		OSR- (56)		COD- (106)		
	Yes	No	Yes	No	Yes	No	Yes	No	
1. There was considerable discussion in meetings of the various Councils and of the Assembly about conditions established by the House or Senate for the receipt of capitation support. Should the Association position be to --									
a) favor pure capitation	35.7%	51.5%	52%	38%	46.4%	50.0%	26.4%	57.5%	
b) accept conditional capitation	63.7%	18.1%	50%	34%	60.7%	33.9%	76.4%	16.0%	
2. Capitation conditions:	Should do	Should not do	Should do	Should not do	Should do	Should not do	Already doing	Would do	Would not do
a) One-time medical student enrollment increase of 5% or 10 students, whichever is greater	61.4%	32.7%	47%	52%	53.6%	44.6%	40.6%	34.9%	23.6%
b) Offering or increasing a program for the training of physicians' assistants	50.9%	43.9%	51%	46%	89.3%	10.7%	47.2%	29.2%	22.6%
c) Secure national service agreements from all entering students, with selection of graduates required to serve through a lottery	19.9%	74.9%	27%	72%	30.4%	67.9%	/////	36.8%	57.5%
d) Secure national service agreements from 25% of entering students	25.7%	70.2%	17%	81%	8.9%	89.3%	/////	44.3%	49.1%
e) Secure national service agreements from 25% of entering students, with each such student entitled to federal support for tuition costs and living expenses	49.1%	45.6%	38%	60%	25.0%	71.4%	/////	65.1%	29.2%
f) Secure agreements from students to repay the school for federal capitation payments in connection with the student's enrollment	24.6%	69.6%	18%	76%	14.3%	83.9%	////	31.1%	63.2%
g) Secure agreements from students to repay the government for capitation payments in connection with the student's enrollment, unless the student serves in the National Health Service Corps	55.6%	39.2%	45%	51%	37.5%	57.1%	////	44.3%	50.0%
h) Prepare a federally approved plan for training all students for at least six weeks at a site away from the medical center, supported by an amount equivalent to at least 25% of the school's capitation grant	30.4%	63.7%	16%	82%	71.4%	26.8%	20.8%	40.6%	34.9%
i) Establish a specified academic unit for primary care training whose faculty size and curriculum duration also would be specified	55.6%	37.4%	37%	61%	85.7%	12.5%	44.3%	29.2%	22.6%
j) Establish residencies in family medicine or comparable primary care field, with program size specified	79.5%	15.2%	68%	30%	91.1%	8.9%	62.3%	29.2%	5.7%
k) Reduce the percentage of foreign medical graduates in affiliated graduate training programs to specified levels	76.0%	20.5%	78%	21%	66.1%	28.6%	20.8%	69.8%	5.7%

[Handouts]

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	<u>COTH</u>		<u>CAS</u>		<u>OSR</u>		<u>COD</u>	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
3. Would you favor direct subsidy to students?	<u>49.7%</u>	<u>47.4%</u>	<u>54%</u>	<u>44%</u>	<u>39.3%</u>	<u>60.7%</u>	<u>27.4%</u>	<u>68.9%</u>
4. If your answer to question 3 was "yes", would you still prefer direct student subsidy if conditions were attached to it similar to existing conditions associated with capitation?	<u>31.0%</u>	<u>24.0%</u>	<u>25%</u>	<u>34%</u>	<u>28.6%</u>	<u>21.4%</u>	<u>9.4%</u>	<u>24.5%</u>
5) Would you favor last-dollar support compared to --								
a) capitation without conditions	<u>37.4%</u>	<u>49.1%</u>	<u>39%</u>	<u>54%</u>	<u>50.0%</u>	<u>44.6%</u>	<u>24.5%</u>	<u>69.8%</u>
b) capitation with conditions	<u>40.9%</u>	<u>45.0%</u>	<u>38%</u>	<u>47%</u>	<u>33.9%</u>	<u>57.1%</u>	<u>30.2%</u>	<u>58.5%</u>
c) direct student subsidy without conditions	<u>31.0%</u>	<u>55.6%</u>	<u>31%</u>	<u>57%</u>	<u>37.5%</u>	<u>53.6%</u>	<u>18.9%</u>	<u>69.8%</u>
d) direct student subsidy with conditions	<u>39.8%</u>	<u>44.4%</u>	<u>39%</u>	<u>46%</u>	<u>28.6%</u>	<u>60.7%</u>	<u>26.4%</u>	<u>62.3%</u>
6) Do you believe there should be a reduction in the number of residency training slots to 125 percent of U.S. medical school graduates, with no change in the distribution of slots among specialties; in order to reduce the number of FMGs?	<u>40.9%</u>	<u>54.4%</u>	<u>52%</u>	<u>46%</u>	<u>32.1%</u>	<u>66.1%</u>	<u>37.7%</u>	<u>59.4%</u>
7) Do you believe there should be control over the distribution of residency training slots among the various specialties (particularly to increase the proportion devoted to preparation of primary care physicians) and over the number of slots (limiting them to 125 percent of U.S. medical school graduates in order to reduce the number of FMGs)?	<u>69.0%</u>	<u>27.5%</u>	<u>57%</u>	<u>42%</u>	<u>37.5%</u>	<u>58.9%</u>	<u>73.6%</u>	<u>25.5%</u>
8) If the answer to question 6 or 7 was "yes", would you prefer that the control be exercised by --								
a) a federal commission	<u>5.8%</u>	<u>64.9%</u>	<u>6%</u>	<u>58%</u>	<u>14.3%</u>	<u>33.9%</u>	<u>6.6%</u>	<u>62.3%</u>
b) the private sector	<u>76.6%</u>	<u>5.8%</u>	<u>69%</u>	<u>6%</u>	<u>35.7%</u>	<u>14.3%</u>	<u>76.4%</u>	<u>5.7%</u>

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766 IRVING AVENUE
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COLLEGE OF MEDICINE
DEPARTMENT OF PATHOLOGY

AREA CODE 315
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October 28, 1974

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

Dear Gus:

You will recall that we had a short discussion at our last Administrative Board Meeting regarding the resolution of the GME Steering Committee regarding the publication by the National Board of the Medical Examiners of rankings of students and schools in Parts I and II of the National Board Examinations. The GME reported considerable concern regarding the influence these examinations exert over curricula. I spoke in favor of the resolution voicing concerns similar to those of the GME.

An even worse concern has now surfaced. It is my understanding that the Board of Trustees of the State University of New York has requested a report from the Deans of the several medical schools in the State University regarding the National Board scores of students at each school. Questions have been asked of representatives of the Administration of our school, which have clear implications that ranking and scores will be used as a method of determining this school's accountability to the State University. I regard this as a flagrant misuse of these scores, and I would so regard it whether our school were first or last in rank. I would therefore recommend that this subject be reintroduced at our next Administrative Board Meeting.

Sincerely,



Rolla B. Hill, Jr., M.D.
Professor and Chairman

RBH/fn

cc: Administrative Board

REPORT OF THE AAMC OFFICERS' RETREAT

December 11-13, 1974

Officers Present:

Dr. Sherman M. Mellinkoff (Chairman)
Dr. John A.D. Cooper (President)
Dr. John F. Sherman (Vice-President)
Dr. Ivan L. Bennett, Jr. (Chairman, COD)
Dr. John A. Gronvall (Chairman-Elect, COD)
Dr. Jack W. Cole (Chairman, CAS)
Dr. Rolla B. Hill (Chairman-Elect, CAS)
Mr. Sidney Lewine (Chairman, COTH)
Mr. Charles B. Womer (Chairman-Elect, COTH)
Mr. Mark Cannon (Chairperson, OSR)
Dr. Cynthia B. Johnson (Vice-Chairperson, OSR)
Dr. Kenneth R. Crispell (Distinguished Service Member)

Staff Present:

Mr. Charles Fentress
Dr. H. Paul Jolly
Dr. Richard Knapp
Dr. Emanuel Suter
Dr. August Swanson
Mr. J. Trevor Thomas
Mr. Bart Waldman
Dr. Marjorie Wilson

The retreat of the Association's officers was held December 11-13 at the Belmont Conference Center, Elkridge, Maryland. Individuals invited to attend included the Chairman and Chairman-Elect of the Association and of each Council, the OSR Chairperson and Vice Chairperson, the "coordinator" of the Distinguished Service Members, and the Executive Staff.

The discussion and recommendations of the retreat participants are presented below in the outline format in which each issue was considered.

I. AAMC Organization and Governance

A. COTH Membership Criteria

Membership criteria proposed by a COTH task force had been presented to the Executive Council and referred back to the COTH Administrative Board to provide for the inclusion of affiliated community hospitals having only a family practice residency. COTH representatives felt that a strong commitment to medical education must be shown by a hospital in order to qualify for COTH membership. The view was expressed that the nomination of an affiliated hospital by a dean might be considered to be sufficient evidence of this commitment. The issue of COTH size was also considered, since it was agreed that COTH should never try to include the over 1500 hospitals having graduate training programs and since some deans had previously expressed the view that COTH had grown too large. It was agreed that hospitals having a significant commitment to medical education should not be excluded and that a new task force which would include deans should be appointed to review the mechanics of accomplishing this.

B. Housestaff Representation

The question of including housestaff representation in the Association was discussed by the retreat participants. The OSR had suggested this item, expressing the belief that house officers should have a voice in Association affairs. A number of alternate methods by which house officers could be included in the Association, either as a governing organization such as the OSR, or in a less formal status, were presented.

Since no formal request had been presented to the Association by any group representing house officers and since a representative of the Physicians National Housestaff Association had expressed some opposition to the idea, the retreat participants felt that no action should be taken at this time. They specifically indicated that the AAMC should avoid, at all costs, giving recognition to any group which might function as a union. In discussing further alternatives, it was emphasized that if residents were to be included, the Association should seek only to represent them as teachers and students. Employee interests of house officers should never be served through the AAMC.

Doctor Bennett expressed the strong feeling that the Association should observe the housestaff situation, waiting until employee issues, which dominate the house officers' interests, calm down. He also felt that the AMA/housestaff relations should be observed for a period of time.

The retreat participants agreed that formal housestaff representation should be postponed, but that the Association should seek qualified housestaff input to appropriate committees and explore the possibility of having the deans or program directors invite house officers to the annual meeting.

C. Report of the Task Force on Groups

A task force of the Executive Council had been appointed to consider the appropriate role of the five existing groups within the AAMC, the most desirable relationship of the groups to the staff and to the Councils, and the appropriate level of staff and financial resources which should be devoted to supporting groups. The task force's report supported the existing organizational structure and allocation of resources. It went on to recommend a formal mechanism by which groups could recommend items to be considered by the Executive Council and the constituent Councils.

The retreat participants expressed their full support for the recommendations of the task force and agreed that the task force report should be circulated immediately to the group chairmen with invitations to the January meeting of the Executive Council.

D. Distinguished Service Members

Doctors Mellinkoff and Crispell discussed the first meeting of the Association's Distinguished Service Members which had been held at the annual meeting in November. The minutes of this meeting were distributed for information.

The retreat participants felt that the role which had been identified by the Distinguished Service Members was appropriate and should be pursued with enthusiasm. It was also agreed that some limit on the size of this group be sought in discussions with the Councils which recommend their election. It was also felt that editorials for the Journal of Medical Education should be sought from members of this group.

II. Relationships with Other Organizations

A. CCME, LCME and LCGME

The retreat participants discussed the general structure and function of these three bodies and then addressed specific issues raised in the retreat agenda. It was agreed that Dr. Cooper should be appointed as an AAMC representative to the CCME. It was also felt that expansion of the LCME membership, beyond the current AMA-AAMC composition, should be addressed on the merits of participation by other organizations and should not be handled as a political question. Strong feelings were expressed that at least one, and maybe all of the additional groups being proposed, should not be added on the merits of their contributions to the accreditation of undergraduate medical education.

The question of staffing the CCME was discussed but it was felt to be an issue which should not be confronted until some problem arose regarding the staffing by the AMA. It was also felt that the question of which policies should be forwarded to the CCME and which policies should be considered independently by the AAMC should be addressed on an individual issue-by-issue basis.

B. Association for Academic Health Centers and Federation of Associations of Schools of the Health Professions

Relationships with groups representing schools of other health professions were reviewed. It was agreed that the Association's close liaison with the AAHC should be continued as in the past. Special relationships with groups representing dentistry, nursing and public health were strongly supported. It was felt that the Federation should only serve as a forum for discussion and should not be used to advance positions on national legislation.

III. Staff Activities

A. Resource Allocation

Doctor Sherman reviewed in detail the process by which the staff was attempting to identify component activities and assign dollar allocations on an actual time and dollars spent basis. He outlined the methodology for this process which included the establishment of a Program and Budget Review Committee and would eventually include a system of evaluation of each of the component staff activities. The retreat participants were presented with an array of 148 distinct activities, along with a description of each and the number of person years devoted to each. Doctor Sherman also presented the dollar allocations devoted to four of the aggregate categories of activities, as well as an array of the percentage of Association manpower being assigned to each general classification.

The retreat participants supported the concept of the program budgeting and expressed the view that this activity would be more useful as an internal educational tool than for any other purpose. It was stressed that the figures would never be accurate and should not be relied on too heavily. Mr. Lewine indicated that if the figures were within ten percent of the actual numbers, the Association would be doing well. He also expressed a strong feeling that any attempt to determine priorities through a mechanism of program assessment would be futile.

The mechanics of the study were reviewed and the feeling expressed that the personnel figures presented needed to reflect dollar expenditures and not simply person years. The treatment of Federal Liaison activities by including them in the substantive areas was supported.

Doctor Bennett reminded the retreat that priorities must also be looked at in terms of which activity, when reduced, will save the most dollars. This meant that a decision to cut back an activity would be meaningless unless the number of people and/or the travel funds could be reduced.

It was agreed that the January Executive Council meeting would be presented with the process being undertaken. Representatives of each Council would be asked to assess the expectations of the Council members regarding this display and its ultimate effect on the setting of priorities. The retreat participants also discussed inconclusively the concept of asking a management consultant to work with the Association on this activity.

B. Space Requirements

Doctor Cooper and Mr. Thomas discussed the activities of the Building Committee, the expanded space requirements of the Association, and the Washington, D.C. real estate market. The Building Committee had recommended that the staff actively seek either the outright purchase of an existing facility or the leasing, with option to buy, of office space where the staff activities could be consolidated. Mr. Thomas indicated that market conditions in the Washington area were extremely unfavorable to this type of action. It was recommended that the AAMC continue to lease space at One Dupont Circle and elsewhere as needed. More favorable market conditions are anticipated within two to three years.

The retreat participants concurred in this recommendation, adding that it would be psychologically disadvantageous to purchase office space at a time when general economic conditions affecting the constituency were so restricting.

IV. Physician Production and Distribution

A. Federal Support of Medical Education

The retreat participants reviewed the steps which had been taken since the meeting of the Assembly to reconsider the Association's position on health manpower legislation. They agreed with the appointment of a Task Force on Health Manpower, chaired by Dr. Daniel Tosteson, and reviewed the questionnaire which had been sent to the full AAMC membership. It was felt that the substantive consideration of health manpower policies should be left to the task force with recommendations to come before the Executive Council.

In anticipation of the task force report, it was recommended that meetings be arranged with potentially influential individuals. The discussion then turned to suggestions of people who would be appropriate contacts with House and Senate leaders. It was also suggested that deans and hospital directors be encouraged to visit nearby, underserved areas to establish the basis for future outreach programs.

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ANALYSIS OF RESPONSES TO HEALTH MANPOWER SURVEY
OF CAS REPRESENTATIVES AND OFFICERS

The CAS was surveyed through a questionnaire in early December, 1974 in order to obtain the views of the Council on the major issues surrounding Federal health manpower legislation; 290 questionnaires were mailed and 125 (43%) were returned.

The respondents represented 56 of the 58 member societies for a mean frequency of response of 2.12 per society; 13 societies provided 1 response, 23 provided 2, 14 provided 3, 4 provided 4, and 1 provided 5. 106 clinicians responded, only 19 basic scientists returned the questionnaire.

The responses are detailed below.

1. *There was considerable discussion in meetings of the various Councils and of the Assembly about conditions established by the House or Senate for the receipt of capitation support. Should the Association position be to --*

a) *continue opposing any requirements for basic capitation support for the cost of medical education?*

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	10 (9%)	57 (54%)	39 (37%)
Basic Scientists	2 (11%)	8 (42%)	9 (47%)
Overall	12 (10%)	65 (52%)	48 (38%)

b) *accept the inevitability of conditions on capitation and seek to limit them to those to which most schools can respond?*

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	19 (18%)	51 (48%)	36 (34%)
Basic Scientists	1 (5%)	11 (58%)	7 (37%)
Overall	20 (16%)	62 (50%)	43 (34%)

2. *Regardless of your answer to Question 1, of the following conditions that have been included in recent or current health manpower bills, which ones do you believe the schools should do in order to receive capitation or should not do even if it meant loss of capitation?*

a) *One-time medical student enrollment increase of 5% or 10 students, whichever is greater*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	0 (0%)	48 (45%)	58 (55%)
Basic Scientists	1 (5%)	11 (58%)	7 (37%)
Overall	1 (1%)	59 (47%)	65 (52%)

b) *Offering or increasing a program for the training of physician's assistants*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	1 (1%)	57 (54%)	48 (45%)
Basic Scientists	2 (11%)	7 (37%)	10 (53%)
Overall	3 (2%)	64 (51%)	58 (46%)

c) *Secure national service agreements from all entering students, with selection of graduates required to serve through a lottery*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	1 (1%)	30 (28%)	75 (71%)
Basic Scientists	0 (0%)	4 (21%)	15 (79%)
Overall	1 (1%)	34 (27%)	90 (72%)

d) *Secure national service agreements from 25% of entering students*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	2 (2%)	17 (16%)	87 (82%)
Basic Scientists	1 (5%)	4 (21%)	14 (74%)
Overall	3 (2%)	21 (17%)	101 (81%)

e) *Secure national service agreements from 25% of entering students, with each such student entitled to Federal support for tuition costs and living expenses*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	2 (2%)	41 (39%)	63 (59%)
Basic Scientists	1 (5%)	6 (32%)	12 (63%)
Overall	3 (2%)	47 (38%)	75 (60%)

f) *Secure agreements from students to repay the school for Federal capitation payments in connection with the student's enrollment*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	5 (5%)	22 (21%)	79 (75%)
Basic Scientists	2 (11%)	1 (5%)	16 (84%)
Overall	7 (6%)	23 (18%)	95 (76%)

g) *Secure agreements from students to repay the government for capitation payments in connection with the student's enrollment, unless the student serves in the National Health Service Corps*

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	3 (3%)	47 (44%)	56 (53%)
Basic Scientists	2 (11%)	9 (47%)	8 (42%)
Overall	5 (4%)	56 (45%)	64 (51%)

- h) Prepare a federally approved plan for the training of undergraduate medical students at a site away from the medical center, supported by an amount equivalent to at least 25% of the school's capitation payment

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	2 (2%)	19 (18%)	85 (80%)
Basic Scientists	1 (5%)	1 (5%)	17 (90%)
Overall	3 (2%)	20 (16%)	102 (82%)

- i) Establish a specified academic unit for primary care training whose faculty size and curriculum duration also would be specified

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	1 (1%)	40 (38%)	65 (61%)
Basic Scientists	2 (11%)	6 (32%)	11 (58%)
Overall	3 (2%)	46 (37%)	76 (61%)

- j) Establish residencies in family medicine or comparable primary care field, with program size specified

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	2 (2%)	71 (67%)	33 (31%)
Basic Scientists	0 (0%)	14 (74%)	5 (26%)
Overall	2 (2%)	85 (68%)	38 (30%)

- k) Reduce the percentage of foreign medical graduates in affiliated graduate training programs to specified levels

	<u>No Response</u>	<u>Should Do</u>	<u>Should Not Do</u>
Clinicians	1 (1%)	81 (76%)	24 (23%)
Basic Scientists	0 (0%)	17 (90%)	2 (11%)
Overall	1 (1%)	98 (78%)	26 (21%)

3. Would you favor eliminating capitation with conditions and substituting direct subsidy to students, which would permit schools to increase tuition to meet more closely the costs of education?

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	2 (2%)	60 (57%)	44 (42%)
Basic Scientists	0 (0%)	8 (42%)	11 (58%)
Overall	2 (2%)	68 (54%)	55 (44%)

4. If your answer to Question 3 was "yes", would you still prefer direct student subsidy if conditions were attached to it similar to existing conditions associated with capitation?

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	40 (38%)	29 (27%)	37 (35%)
Basic Scientists	12 (63%)	2 (11%)	5 (26%)
Overall	52 (42%)	31 (25%)	42 (34%)

5. Would you favor last-dollar support (a varying amount, individualized for each school, for that portion of the operating budget not covered by income from other sources), with Federal requirements for certain institutional financial and other records, to --

a) *Capitation without conditions*

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	8 (8%)	42 (40%)	56 (53%)
Basic Scientists	0 (0%)	7 (37%)	12 (63%)
Overall	8 (6%)	49 (39%)	68 (54%)

b) *Capitation with conditions*

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	14 (13%)	40 (38%)	52 (49%)
Basic Scientists	4 (21%)	8 (42%)	7 (37%)
Overall	18 (14%)	48 (38%)	59 (47%)

c) *Direct student subsidy without conditions*

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	12 (11%)	30 (28%)	64 (60%)
Basic Scientists	3 (16%)	9 (47%)	7 (37%)
Overall	15 (12%)	39 (31%)	71 (57%)

d) *Direct student subsidy with conditions*

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	14 (13%)	42 (40%)	50 (47%)
Basic Scientists	4 (21%)	7 (37%)	8 (42%)
Overall	18 (14%)	49 (39%)	58 (46%)

6. Do you believe there should be a reduction in the number of residency training slots to 125 percent of U.S. medical school graduates, with no change in the distribution of slots among specialties, in order to reduce the number of FMGs?

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	2 (2%)	53 (50%)	51 (48%)
Basic Scientists	1 (5%)	12 (63%)	6 (32%)
Overall	3 (2%)	65 (52%)	57 (46%)

7. Do you believe there should be control over the distribution of residency training slots among the various specialties (particularly to increase the proportion devoted to preparation of primary care physicians) and over the number of slots (limiting them to 125 percent of U.S. medical school graduates in order to reduce the number of FMGs)?

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	1 (1%)	58 (55%)	47 (44%)
Basic Scientists	1 (5%)	13 (68%)	5 (26%)
Overall	2 (2%)	71 (57%)	52 (42%)

8. If the answer to Question 6 or 7 was "yes", would you prefer that the control be exercised by --

a) A federal commission whose members would be appointed by the HEW Secretary?

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	40 (38%)	6 (6%)	60 (57%)
Basic Scientists	4 (21%)	2 (11%)	13 (68%)
Overall	44 (35%)	8 (6%)	73 (58%)

b) The private sector, through a non-government group such as the Coordinating Council of Medical Education?

	<u>No Response</u>	<u>Yes</u>	<u>No</u>
Clinicians	28 (26%)	71 (67%)	7 (7%)
Basic Scientists	3 (16%)	15 (79%)	1 (5%)
Overall	31 (25%)	86 (69%)	8 (6%)

12/31/74

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum

January 7, 1975

From: Prentice Bowsher

Subject: Draft Report of the AAMC Task Force on Health Manpower

Following the November 1974 Assembly debate in Chicago on the Association's policy on federal legislation for health professions education assistance, an AAMC Task Force was appointed on health manpower. Named as chairman of the Task Force was D.C. Tosteson, M.D., Chairman, Department of Physiology and Pharmacology, Duke University School of Medicine. Members of the Task Force were Steven C. Beering, M.D., Dean, Indiana University School of Medicine; Robert Berliner, M.D., Dean, Yale University School of Medicine; Arnold S. Relman, M.D., Chairman, Department of Medicine, The University of Pennsylvania School of Medicine; Clayton Rich, M.D., Dean, Stanford University School of Medicine; Cheves Smythe, M.D., Dean, The University of Texas Medical School at Houston; Charles C. Sprague, M.D., President, The University of Texas Health Sciences Center at Dallas; David D. Thompson, M.D., Director, New York Hospital; Ernest Turner, University of Kansas Medical Center.

The Task Force met in Washington, D.C., on December 18 and 19, 1974, and on January 3 and 4, 1975. It reviewed existing Association health manpower policy and legislative developments since the adoption of the policy in December 1973. Based on its review, it developed a tentative set of legislative recommendations on federal assistance for health professions legislation which were reviewed in turn with key staff persons from the Congress and the Department of Health, Education and Welfare. Some of the tentative recommendations were later modified, and a final set of recommendations was prepared for consideration by the Association's Executive Council.

In developing its recommendations, the Task Force considered a variety of funding mechanisms, including last-dollar support and direct student subsidies. It considered a variety of ways in which commitments from medical students could be secured to practice in underserved areas. The agreements represented in the recommendations reflect a consensus of the Task Force members and the Association's various constituencies. In developing its recommendations the Task Force accepted the position that medical schools have incurred obligations to address national health concerns in return for consideration as national resources. The Task Force was also acutely aware of differing capabilities among medical schools, because of geographic, demographic or educational variations, for meeting the whole range of national health concerns. As a result, the Task Force recommended a series of important projects for medical schools to carry out in return for federal assistance and required each school to agree to undertake a certain number of such projects. The legislative recommendations of the Task Force were designed to address four priority concerns related to health personnel in the United States: aggregate supply, geographic distribution, specialty distribution, and foreign medical graduates. Specific recommendations directed to each of these concerns are shown below.

Aggregate supply: A basic level of capitation based on a methodology developed by the Institute of Medicine under provisions of the 1971 health manpower legislation is recommended to enable schools to maintain enrollment. Additional capitation payments are available for carrying out certain optional projects. Among the recommended optional conditions for capitation support are enrollment increases of undergraduates and expansion or establishment of training programs for physicians' assistants.

Geographic distribution: The National Health Service Corps is to be strengthened and upgraded by increasing National Health Service Corps scholarships, by modifying and improving the delivery of services by the Corps, and by providing increased opportunities for academic medical centers to support health care delivery by the Corps. Among the recommended optional capitation conditions are recruitment of students from underserved areas; and support for off-campus health care training programs in underserved areas.

Specialty distribution: Among the recommended optional capitation conditions are provisions for increasing primary care residencies in affiliated general hospitals and for operating undergraduate primary care programs in ambulatory settings. Project grant authority is provided for primary care residencies and for undergraduate training in primary care. Authority is provided for the Secretary and either a specially named national advisory commission or the Coordinating Council on Medical Education to correct maldistribution among specialties.

Foreign medical graduates: It is recommended to amend the appropriate immigration statutes to remove the special preference status for alien physicians.

In recognition of the waning time in the present fiscal year, the Task Force strongly recommends the development of four-year legislation -- from fiscal 1975 through fiscal 1978 -- with the first year of such a bill comprised of a simple one-year extension of recently expired legislative authorities. Such an approach to fiscal 1975 funding, it is felt, would permit nearly normal administrative handling of fiscal 1975 assistance awards in late June 1975, without the vagaries of funding associated with a continuing appropriations resolution. Substantive new legislative provisions would first apply to grants in fiscal 1976, and would continue to apply for fiscal 1977 and fiscal 1978.

Following are the Task Force's recommendations for the substantive new provisions of legislation authorizing federal assistance to health professions education.

LEGISLATIVE RECOMMENDATIONS

Capital Support

Construction

Grants and guaranteed loans with interest subsidies are continued.

Maximum grant assistance is 80 percent.

Priority for assistance: ambulatory facilities for primary care teaching; replacement or modernization of existing teaching facilities; new construction required for enrollment increases.

Grant authorization is \$100 million annually.

Guaranteed-loan interest subsidy authorization is \$1-\$2-\$3 million.

Student Assistance

National Health Service Corps scholarships

Year-for-year service requirement, minimum two years' service, in the Corps or elsewhere at the discretion of the Secretary.

Private practice option, with federal guarantee of Corps salary.

Recruitment bonus of \$15,000 for previous nonparticipants who agree to serve at least two years in a shortage area and who have completed three years of post-M.D. training.

Re-enlistment incentives are to be provided through the uniformed services special pay structure as enacted in PL 93-274 (up to \$13,500 per year).

Extension bonus for participants agreeing to remain in shortage area as private practitioners of \$12,500 for one-year extension, \$25,000 for two years or more, such funds to be available for equipment, renovation of facilities, and operating expenses.

Period of service is to begin at the end of the third post-M.D. year for participants engaged in training in family medicine, general internal medicine, general pediatrics or obstetrics-gynecology, and at the end of the second post-M.D. year for other participants unless deferred by the Secretary.

Authorization is \$50-\$100-\$150 million.

Health professions loans

Mandatory notification of loan forgiveness.

Loan ceiling is tuition plus \$3,000.

Assistance available only to students with exceptional financial need.

25 percent forgiveness per year of any educational loan for practice in a shortage area designated under section 329.

Interest rate is increased from 3 to 7 percent.

Authorization is \$30-\$22.5-\$15 million.

Health professions scholarships

Scholarship ceiling is tuition plus \$3,000.

Assistance available only for first- and second-year students of exceptional financial need.

Authorization is \$30-\$22.5-\$15 million.

Shortage areas scholarships

To be phased out, with only previously assisted students eligible for aid. Authorization is such sums as may be necessary.

Loans, scholarships for USFMGs

To be repealed.

Institutional Assistance

Capitation

Up to 1/3 of medical schools' net education cost as determined by a procedure developed by the Institute of Medicine under 1971 health manpower legislation. (Current determination is \$3,250.)

\$1,000 for physicians' assistants.

Authorization for undergraduates (M & O) is \$186-\$194-\$201 million.

Authorization for physicians' assistants (M & O) is \$2-\$3-\$4 million.

Authorization for phasing out enrollment bonus students is such sums as may be necessary.

Conditions for capitation

Eligibility for first-half of capitation payment requires maintenance of enrollment and maintenance of nonfederal financial support.

Eligibility for second-half of capitation payment requires, in addition, assurances of carrying out at least one project in each of any two of the following areas:

1. Aggregate supply --

a) Increase first-year medical student enrollment by the greater of 5 percent or 10 students over a base year, provided that a school may offer an equivalent number of advanced standing places to students otherwise eligible for admission who previously were enrolled in non-M.D. programs, in non-M.D.-granting institutions, or in schools outside the United States;

b) Establish a physician assistant training program of at least 25 students, or expand an existing program by at least 25 percent.

2. Geographic distribution --

a) Increase first-year enrollment of students from shortage areas as determined by section 329 by 10 students over a base year; or

b) Earmark an amount satisfactory to the Secretary from any source for support of an off-campus undergraduate and/or graduate training program serving a shortage area. Such a program may be an area health education center, support of an NHSC delivery unit, or a remote-site care experience.

3. Specialty distribution --

a) Beginning with the initial application for funds under this section, primary care residency positions (defined to be family practice, general internal medicine, general pediatrics, and obstetrics-gynecology) in affiliated general hospitals are to be increased annually by at least 5 percent of all residencies in affiliated general hospitals, so long as the percentage of such positions is less than 50 percent;

b) Maintain primary care residency positions in affiliated general

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hospitals of at least 50 percent of all such positions; or

c) Establish or expand one or more undergraduate programs which are determined by the Secretary to be operated in an ambulatory care setting devoted to education in primary care, and which are enrolling each year a number of students satisfactory to the Secretary.

Conditions are to become effective beginning in the 1976-77 academic year, except as noted.

Start-up, conversion

To be phased out, with only previously assisted schools eligible for aid.

Authorization is such sums as may be necessary.

Deficit sharing (no financial distress)

Authorization is \$20 million annually.

Specialized Assistance

Special projects

1. Interdisciplinary training among professions, including team care.
2. Training in alcohol and drug abuse.
3. Improve the curriculum or undertake experimental teaching projects.
4. Training in the use of the problem-oriented patient record and the use of computer technology in health care delivery.
5. Recruitment and admissions of students from underserved areas.
6. Training in the provision of emergency medical services, with emphasis on team care.
7. Training in sensitivity to polycultural attitudes regarding health care and health personnel, including bilingual clinical training.
8. Training in the ethical, social, legal and moral implications of advances in biomedical research and technology.
9. Training in the science of human nutrition as it relates to the diseases and impairments of human beings.
10. Training in sensitivity towards attitudes about health care and health problems of older persons and females.
11. Training in rehabilitative medicine and in sensitivity to handicapped persons.

Authorization is \$75 million annually.

Health Manpower education initiative awards

Revise to support area health education centers which are to be used for remote-site undergraduate and graduate training in primary care, for continuing medical education of local health personnel, for general health education of the public, provided that each such center be located in an underserved area and include participation by a medical school.

Authorization is \$40-\$70-\$75 million.

Recruitment of disadvantaged students

Authorization is \$20 million annually.

Primary care residencies

Authorization is \$40-\$50-\$50 million.

Primary care undergraduate training

Provide project-grant assistance for undergraduate training in primary care in ambulatory settings.

Authorization is \$10-\$15-\$20 million.

Bilingual training centers

Provide project-grant assistance for up to four bilingual health training clinical centers in affiliation with academic medical centers.

Authorization is \$2.5 million annually.

General health education

Provide project-grant support for projects to educate the public about health.

Authorization is \$5-\$10-\$15 million.

Shortage area support

Provide project-grant assistance for academic medical centers to provide professional support and backup services for health care personnel or organizations, such as NHSC Health Care Delivery Units, in underserved areas designated under section 329.

Authorization is \$10-\$20-\$30 million.

Other Provisions

National advisory council membership

Revise the composition of the 20 appointed members to be 12 representatives of health professions schools, including at least six persons experienced in academic health center administration; two full-time health professions students; and six members of the general public.

FMG immigration

Amend the Immigration and Nationality Act to remove special preference visas for alien physicians.

Graduate medical training

Designate the Liaison Committee on Graduate Medical Education as the agency responsible for accrediting graduate medical education programs. Authorize the Secretary with approval of a special advisory group to designate the number of accredited residency positions which are to be eligible for third-party reimbursement. The objectives of such a mechanism are to insure a close matching of residency positions and numbers of U.S. medical school graduates and to distribute specialty training according to national needs.

Preferred advisory group:. Comprised of the Coordinating Council on Medical Education.

Alternate advisory group: Comprised of the HEW Assistant Secretary for Health, the HEW Administrator of the Health Resources Administration, the VA Chief Medical Director, and the President of the Uniformed Services University of the Health Sciences, ex officio without votes; and 19 members appointed by the Secretary of which 10 are to be nominated by the AMA, AHA, AAMC, ABMS, CMSS, provided that no more than 2 are to represent a single group; 1 is to be nominated by the American Osteopathic Association; 1 is to be nominated by the American Association of Colleges of Osteopathic Medicine; 6 are to be consumers of health care services who are not providers of health services; and one is to be a full-time resident.

Health manpower report

The Secretary with approval of a special advisory group is directed to report annually to the Congress on national health personnel needs by professions, by specialty, and by geographic region. The advisory group shall consist of 10 persons appointed by the Secretary who by their training and experience are eminently qualified to assess health personnel needs, provided that no member of the group shall be an employee of the federal government.

National Health Service Corps

Provide that Corps delivery of health services is to be through 4-5 physician Health Care Delivery Units, comprised of physicians and appropriate other health personnel.

Application for a unit would be by an underserved area or group of areas, after consultation with the appropriate medical society, which can provide assurances of sharing the cost of providing and equipping adequate facilities for a unit, provided that the Secretary may waive the cost-sharing requirement if a community is financially unable to meet it.

Underserved areas in remote locations with populations unable to support a unit may enter agreement with an existing unit to provide services on a circuit-rider basis.

Underserved areas covering large distances may enter federal cost-sharing agreements to provide appropriate communications and transportation systems.

Health care delivery units are to charge for their services on a fee-for-service or prepayment basis.

Health care delivery units may enter agreements with academic medical centers to provide backup for activities and develop appropriate referral patterns for patient requiring specialized care; to provide technical assistance in the development of appropriate communication and transportation networks; to provide continuing education for Corps personnel; to provide general education for the public on health.

Authorization is \$25-\$35-\$50 million.