

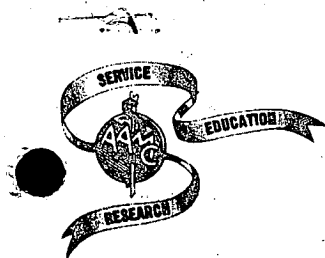
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD
RETREAT

June 18, 1975

10:00 a.m.	Biomedical Research Problems*	<i>Vermont Suite Mayflower Hotel</i>
1:00 p.m.	Lunch	<i>Vermont Suite</i>
2:30 p.m.	Undergraduate and Graduate* Medical Education (probable impact of recent and impending legislation and regulation)	<i>Vermont Suite</i>
6:30 p.m.	Cocktails	<i>Maryland Room Mayflower Hotel</i>
7:30 p.m.	Dinner	<i>Maryland Room</i>
9:00 p.m.	<i>Guest Speaker:</i> Donald Frederickson, M.D. Director, NIH	<i>Maryland Room</i>
10:00 p.m.	Adjourn	

* Please refer to memorandum of May 28, 1975 for subject matter



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

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 18, 1975

10:00 a.m.	Administrative Board Retreat	<i>Vermont Suite Mayflower Hotel</i>
6:30 p.m.	Cocktails and Dinner	<i>Maryland Room Mayflower Hotel</i>
	<i>Guest Speaker:</i>	
	Donald Frederickson, M.D. Director, NIH	

June 19, 1975

8:30 a.m.	Administrative Board Business Meeting <i>(Coffee and Danish)</i>	<i>Room 827 One Dupont Circle</i>
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon	<i>Dupont Room Dupont Plaza Hotel</i>
	Executive Council Business Meeting	
4:00 p.m.	Adjourn	

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 19, 1975

I. REPORT OF THE CHAIRMAN

II. ACTION ITEMS:

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3. Membership Applications:
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2. Annual Meeting Plans

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MINUTES
 ADMINISTRATIVE BOARD
 COUNCIL OF ACADEMIC SOCIETIES
 Washington, D.C.
 April 3, 1975

NOTE: The CAS Spring Meeting was held in Bethesda, Maryland, convening on the afternoon of March 31 and adjourning at noon on April 1. An overview of the meeting is included in the Information Items of these MINUTES. A special session of the CAS Administrative Board meeting was held (beginning with lunch on April 1 and adjourning at 2:30 p.m.) to discuss the agenda for the April 3 meeting. The minutes reported here reflect the consensus of the CAS Administrative Board in both the April 1 and April 3 (regularly scheduled) sessions. Some Board members attended only the April 1 session, some only the April 3 session, and some attended both sessions. Attendance is appropriately designated.

PRESENT:	<u>Board Members</u>	<u>Session Attended</u>
	Jack W. Cole Chairman (Presiding)	April 3
	Robert M. Berne	April 3
	F. Marion Bishop	April 1
	A. Jay Bollet	April 3
	Garmine D. Clemente	April 1 and 3
	Ronald W. Estabrook	April 1 and 3
	Rolla B. Hill, Jr.	April 1
	Thomas K. Oliver, Jr.	April 1
	Leslie T. Webster	April 1
ABSENT:	Robert G. Petersdorf*	

PRESENT:	<u>Staff</u>	
	Vickie Bardolf	April 1 and 3
	Helen Eden	April 3
	James B. Erdmann	April 1 and 3
	Hilliard Jason	April 3
	Mary H. Littlemeyer	April 1 and 3
	Thomas E. Morgan	April 1 and 3
	Luis Patino	April 3
	Mignon Sample	April 1 and 3
	August G. Swanson	April 1 and 3

*Ex Officio

I. Adoption of Minutes

The minutes of the CAS Administrative Board of January 15, 1975, were adopted as circulated.

II. Action Items

The CAS Administrative Board considered the following action items on the Executive Council agenda:

A. Resignation of Dr. Grulee

ACTION: The CAS Administrative Board noted with regret the resignation of Dr. Clifford G. Grulee from the Executive Council. No official action was deemed necessary, and, therefore, none was taken.

B. Ratification of LCME Accreditation Decisions

ACTION: The CAS Administrative Board reviewed the accreditation recommendations (as set forth in the Executive Council agenda on pages 19-20). No official action was deemed necessary, and, therefore, none was taken.

Dr. Estabrook, who serves on the LCME and who was unable to be present at the January meeting of the CAS Administrative Board, discussed the problems and basic purposes of the accreditation process. In addition, he spoke in particular of the situation at the Chicago Medical School. Through the efforts of the accreditation team, working with the CMS, solutions are being reached, and there is every reason to be optimistic about the ultimate elevation of programs to permit the CMS to achieve acceptable standards. The admissions problem has been rectified. The CAS Administrative Board does not receive full reports of the LCME. These reports are confidential and are transmitted to the dean of the school, the president, and the chairman of the board of the parent university. The report is theirs to use as they deem appropriate, but from the standpoint of the official accrediting agency (the LCME), the report is confidential. There are recent pressures from student groups to make this information public. This was reflected in the feature article in the March 1975 issue of The New Physician, entitled "The LCME: Medical Education's Watchdog." The general bias of the story is apparent from the subheadings used:

Accreditation -- Power to Judge

Accreditation -- Potential for Abuse

How Accreditation Works in Theory

The Arizona Story -- How Accreditation Works in Fact

The final five pages, called "The View from Inside," consists of interviews with LCME "insiders," such as C.H. William Ruhe of whom the interviewer asked:

"Can you recall incidents where accreditation has been used to get rid of individuals?"

"...if it's a public action, why can't the public see it?"

C. Role of Research in Medical School Accreditation

ACTION: The CAS Administrative Board reaffirmed its position with regard to the role of research in medical school accreditation (as set forth in the recommendation to the Executive Council on page 21 of the Executive Council agenda). Since this recommendation had originated in the Council of Academic Societies' Board, pursuant to the recommendation transmitted by a CAS constituent, the Association of Chairmen of Departments of Physiology, no additional action was deemed necessary, and, therefore, none was taken.

Dr. Swanson reported that the OSR had considered the resolution and had approved the first clause, which follows:

"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."

but that it did not approve the second clause, which follows:

"and that the AAMC ensures that all accreditation survey teams include at least one recognized investigator in the biomedical sciences."

It was, according to Dr. Swanson, the consensus of the OSR that the authority and the responsibility for formulating the accreditation teams should reside with the LCME.

While it was decided that CAS representatives to the Executive Council should defend the motion as presented, there was a discussion to clarify how one might define an "identifiable component which addresses itself to the quantity and quality of biomedical research." Dr. Berne, whose society originated the resolution, said his interpretation was that every department should have some research. When Dr. Estabrook observed that many departments could not fulfill this criterion, Dr. Bollet suggested that in such cases the unit might more appropriately be a division rather than a department. He added that he would find "quality" difficult to define. Relative to Dr. Berne's comment, it was pointed out, however, that the resolution related to the "evaluation of medical schools" not of departments per se. Dr. Estabrook referred to the current document that serves as the basis on which the accreditation process is carried out. Because it is germane to this entire discussion, this document, "The Functions and Structure of a Medical School," have been reproduced and follows as a part of these minutes.

FUNCTIONS & STRUCTURE OF A MEDICAL SCHOOL

Statement by

**The Liaison Committee on
Medical Education**

of

**The Association of
American Medical Colleges**

and

**The Council on Medical Education
American Medical Association**

Approved by

**The Assembly of
The Association of
American Medical Colleges**

November 1972

and

**The House of Delegates of
The American Medical Association**

June 1973

I. Introduction

This is a statement of the Liaison Committee on Medical Education, of the Association of American Medical Colleges, and of the Council on Medical Education of the American Medical Association.* 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.

II. Definition and Mission

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. The educational program must be sponsored by an academic institution that is appropriately charged within the public trust to offer the M.D. degree.

As an institution of higher education, a medical school has four inherent responsibilities which embody the concept of a continuum of education throughout professional life. These are:

- A. 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 lifelong habits of scholarship and service.
- B. A medical school is responsible for the advancement of knowledge through research. In addition to biologically oriented studies, the research car-

*For programs of two years or less, see *Special Criteria for Programs in the Basic Medical Sciences.*

ried on in a medical school may include studies related to cultural and behavioral aspects of medicine, methods for the delivery of health care, and the medical education process.

- C. 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.
- D. 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.

In addition, the resources that characterize the modern academic medical center constitute a unique instrument for meeting selected community or regional health needs. 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. These efforts can serve as models for students.

Participation by medical schools may contribute to the educational programs of other professions in the health field, such as dentistry, nursing, pharmacy, and the allied health professions.

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. When objectives are clearly defined, they should be made familiar to faculty and students alike, so that efforts of all will be directed toward their achievement. Schools should be cautious about overextending themselves in the field of research or service to the detriment of their primary educational mission.

III. Educational Program

The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training pe-

riod which will vary in length depending upon the type of practice the student selects. Further, there is no single curriculum that can be prescribed for the undergraduate period of medical education. 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. The student should be comfortably familiar with the methods and skills utilized in the practice of clinical medicine. 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. At the same time, it 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.

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. Instruction should stress the physician's concern with the total health and circumstance of patients and not just their diseases. 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.

IV. Administration and Governance

A medical school should be incorporated as a non-profit institution. Whenever possible it should be a part of a university since a university can so well provide the milieu and support required by a medical school. 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. 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.

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. 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. 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.

In universities with multiple responsibilities in the health fields in addition to the school of medicine as, for example, schools of dentistry, pharmacy, or nursing, it may be useful to have a vice-president for health affairs, or a similarly designated official, who is responsible for the entire program of health-related education at the university. Ordinarily, the deans of the individual health-related schools would report to this individual.

The medical school should be organized so as to facilitate its ability to accomplish its objectives. Ordinarily, this is best effected through the development of a committee structure that is representative of such concerns as admissions, promotions, curriculum, library, and animal care. Names and functions of the committees established should be subject to local determination and needs. Consideration of student representation on all committees is both desirable and useful.

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.

V. Faculty

The faculty must consist of a sufficient number of identifiable representatives from the biological, be-

havioral, and clinical sciences to implement the objectives that each medical school adopts for itself. The specific fields represented do not have to be reflected in any set pattern of departmental or divisional organization although 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. 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.

The extent to which the school's educational program may depend on the contributions of physicians who are practicing in the community will vary with many factors, including the size of the community and the availability of qualified teachers in the several medical specialties. The advantage to the student of instruction by such physicians, as well as by those in full-time academic service, should be kept in mind.

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. Reasonable security and possibility for advancement in salary and rank should be provided.

A small committee of the faculty should work with the dean in setting medical school policy. While such committees have typically consisted of the heads of the major departments, they may be organized in any way that would bring reasonable and appropriate faculty and student influence into the governance of the school. 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.

VI. Students

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. Inasmuch

as all medical schools constitute a national resource, and all operate in the public interest, it is desirable for the student body to reflect a wide spectrum of social and economic backgrounds. Decisions regarding admission to medical school should be based not only on satisfactory prior scholastic accomplishments but also on such factors as personal and emotional characteristics, motivation, industry, resourcefulness, and personal health. Information about these factors can be developed through personal interviews, college records of academic and non-academic activities, admission tests, and letters of recommendation. There should be no discrimination on the basis of sex, creed, race, or national origin.

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. 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. 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.

Advanced standing may be granted to students for work done prior to admission. The increasing diversity in medical school curricula and the greater integration of the total curriculum require that transfers between medical schools 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. Otherwise, supplementation of the student's program may be necessary after he has transferred.

There should be a system for keeping student records that summarizes admissions, credentials, grades, and other records of performance in medical school. These records should reflect accurately each student's work and qualifications by including a qualitative evaluation of each student by his instructors.

It is very important that there be available an adequate system of student counselling. Such counselling is especially critical for those students who may require remedial work. Academic programs allowing students to progress at their own pace are desirable.

There should be a program for student health care that provides for periodic medical examination and adequate clinical care for the students.

VII. Finances

The school of medicine should seek its operating support from diverse sources. The support should be sufficient for the school to conduct its programs in a satisfactory manner and it should reflect, as accurately as possible, the educational, research, and service efforts of the faculty.

Special attention must be paid to providing financial aid for students since it is desirable that economic hardship not hinder the acquisition of an education in medicine.

VIII. Facilities

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. Geographic proximity between the preclinical and clinical facilities is desirable, whenever possible. 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, and a library.

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. All affiliation agreements should define clearly the rights of both the medical school and the hospital in the appointment of the attending staff. 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.

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. The library should receive the leading medical periodicals, the current numbers of which should be readily accessible. 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. A professional library staff should supervise the development and operation of the library.

IX. Accreditation

The American Medical Association through its Council on Medical Education and the Association of American Medical Colleges serve as the recognized accrediting agencies for medical schools. Though retaining their individual identities, both groups work very closely in this activity through the Liaison Committee on Medical Education. To be accredited, a medical school must be approved by the Liaison Committee on Medical Education, by the Council on Medical Education and be offered membership in the Association of American Medical Colleges. This is granted on the finding of a sound educational program as a result of a survey conducted by the Liaison Committee on Medical Education. The Liaison Committee representing the voluntary professional sector includes a representative from the government and the public, and is recognized by the National Commission on Accrediting, the United States Commissioner of Education, the NIH Bureau of Health Manpower Education, and various state licensure boards as providing the official accreditation for medical education.

It is the intent that newly developing medical schools should be surveyed several times during the initial years of active existence. Provisional accreditation is granted, when the program warrants, for the first two years of the curriculum and definitive

action is taken during the implementation of the last year of the curriculum.

Existing medical schools are surveyed at regular intervals. Decisions regarding accreditation require assessment of the school's constellation of resources in relation to the total student enrollment. Any significant change in either should be brought to the attention of the Liaison Committee and may occasion review of the accreditation. Every attempt is made to fulfill requests for interim surveys as a service to the medical schools.

Further information about accreditation can be obtained from the Secretary, Council on Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, or from the Director, Department of Institutional Development, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036.

D. OSR Recommendation to Establish an Office of Women's Affairs

ACTION: The CAS Administrative Board unanimously adopted the recommendation (as set forth in the Executive Council agenda on page 23) that the Executive Council not approve the OSR recommendation to establish an Office of Women's Affairs. The CAS Administrative Board agreed, in addition, to encourage the AAMC to establish a mechanism by which problems of women in medical education and in their career development might be explored and defined. In cases where a careful monitoring would reveal that significant problems are found to exist, where indicated, appropriate intervention should be offered.

E. Special Recognition of Quigg Newton

ACTION: The CAS Administrative Board noted with interest the recommendation that Mr. Newton's "eminent achievement in promoting and encouraging medical education and biomedical research" receive special recognition. No official action was deemed necessary, and, therefore, none was taken.

F. National Health Insurance and Medical Education

ACTION: The CAS Administrative Board unanimously approved the recommendation regarding National Health Insurance and medical education (as set forth in the Executive Council agenda on page 25).

G. Health Services Advisory Committee Recommendation

ACTION: The CAS Administrative Board unanimously approved the recommendation (as set forth in the Executive Council agenda on page 30) regarding supporting the establishment of a national health professions data base within the National Center for Health Statistics.

III. Discussion Items

A. American Academy of Family Pathologists

The CAS Administrative Board noted with fascination the letter of January 24 to AAMC President John A.D. Cooper on behalf of the American Academy of Family Pathologists. Dr. F. Marion Bishop had written to the President suggesting that the Society of Teachers of Family Medicine would welcome their participation as members.

B. Medical College Admissions Assessment Program Developments

Dr. James B. Erdmann, director of the Division of Education Measurement and Research within the Department of Academic Affairs, reported to the Board on the developments in the MCAAP. The Medical

College Admissions Assessment Program is now in the process of developing a new cognitive examination which will replace the Medical College Admissions Test in the Spring of 1976. This new set of cognitive instruments will provide assessment of applicant students' reading and quantitative skills and achievement in physics, biology and chemistry. The scope of the examination and the new variables measured will provide opportunities for better assessment of the applicant candidates. At the present time criteria for establishing what is relevant to the assessment of students seeking admission to medical school are being reviewed by a large group of experts drawn from CAS society members and from the undergraduate community.

As a part of a more extensive presentation in the CAS Spring meeting on April 1, Dr. Erdmann and Mr. James Angel had shown illustrative items that were in development. Reacting to these, Dr. Clemente expressed concern regarding the time element and made the point that with two applicants of equal academic ability and intelligence, one may have the advantage over the other simply by comprehending the format more readily. Dr. Erdmann explained that practice materials designed to familiarize those who will sit for the exam with both content and format will be provided.

Dr. Erdmann and his staff will welcome the advice of the CAS Administrative Board in the ongoing development of the MCAAP.

C. Division of Faculty Development Program Plans

Dr. Hilliard Jason, director of the Division of Faculty Development within the Department of Academic Affairs, reported to the Board on the developments of this program. This program to assist faculty in analyzing their capabilities as educators and to provide assistance to faculties wishing to improve their educational skills was presented to the Commonwealth and Kellogg Foundations and has been funded for a period of three years. Dr. Jason distributed a summary including the background, program goals, and program activities of the new Faculty Development. In his discussion Dr. Jason explained that the program being designed to enable faculty to undertake self-assessment of their educational effectiveness will be absolutely confidential. Schools may wish to avail themselves of the methods of self-assessment that are being developed to meet their local needs, such as promotions. This would be entirely possible, but no data on individual faculty will be generated by the self-assessment which is confidential.

Dr. Jason and his staff will welcome the advice of the CAS Administrative Board in the ongoing development of their program.

D. CAS Spring Meeting, March 31 - April 1, Bethesda, Maryland

Dr. Thomas E. Morgan, director of the AAMC Division of Biomedical Research, described the two-day Spring Meeting during which the CAS representatives had an opportunity to discuss their concerns for the current programs and future prospects for biomedical research with five of the seven members of the newly appointed President's Biomedical Research Panel on Monday evening, March 31. An estimated total of 70 CAS representatives from 39 CAS organizations attended the session on what turned out to be less than a one-month notice. A summary of the session from the AAMC President (Weekly Activities Report #75-13) follows*:

"Representatives of the 39 academic societies attending the meeting told the Panel that the major problem facing the biomedical research community is the problem of instability in program funding and program direction. The Panel was also told that as a result of diminished support for research training grants there exists a real threat to the future of biomedical research because of the lack of adequate support for young innovative investigators. The problem of the ratio of support for investigator--initiated research versus targeted research was discussed also.

"Benno Schmidt, chairman of the President's Cancer Panel and a member of the Biomedical Research Panel said the Panel 'had high on its list of priorities the problem of instability' and they would be looking for ways to obviate the situation. In talking about research training grants, Schmidt said the decision by the Administration two years ago to phase out support for the program was 'disasterous' and that it had been a long hard road back and that he was 'working the same side of the street' as the AAMC in trying to increase support for traineeships.

"Paul Marks, Vice President for Health Sciences, Columbia University and a member of the Panel raised the question of whether the future of biomedical research should be primarily centered in medical schools. He said that because traditionally most research had been conducted at medical schools didn't mean that it should necessarily continue there. Marks was told that the decision had been made a long time ago not to build a central Federally supported research institute and that the high quality accomplishments of American biomedical research has been credited around the world to the fact that it was being conducted in a University setting.*

"Ron Estabrook, Dean, Graduate School of Biomedical Sciences at the University of Texas Southwestern Medical School, told the Panel how important it is that the GRS program be properly funded.

See "Paul Marks' Views Are Clarified," from Weekly Activities Report #75-15, on page 14.

"The Panel members were appointed by President Ford on January 31, after it was established last July in legislation extending the National Cancer Act. Its duties are to (1) review and assess, (2) identify and make recommendations with respect to policy issues concerning the subject and content of, and (3) identify and make recommendations with respect to policy issues concerning the organization and operation of biomedical and behavior research conducted and supported under programs of the National Institutes of Health and the National Institute of Mental Health. Other members of the Panel who attended the meeting were David Skinner, Chairman, Department of Surgery, University of Chicago Hospitals and Clinics, Ewald Busse, Director, Medical and Allied Health Education, and Associate Provost, Duke University School of Medicine and Albert Lehninger, Director, Department of Physiologic Chemistry, Johns Hopkins University School of Medicine."

Members of the Panel also met with the AAMC Executive Council in Washington on April 4.

In the discussion that ensued, Dr. Estabrook made a motion to recommend that the AAMC through the CAS establish a subcommittee to evaluate and examine faculty stability vis-a-vis tenure and to present alternatives. The motion was not seconded. It was Dr. Estabrook's opinion that studies of tenure have been based on the undergraduate model of the university where the support is from hard money. Data so derived would have limited value when applied to the medical school setting where so much faculty support comes from research funding.

Dr. Swanson indicated that whereas it would probably not be feasible for AAMC to take a stand for or against tenure that it probably needed to develop a list of the signs and symptoms of instability of the medical school, one of which is tenure.

E. Longitudinal Study of Faculty Graduating in 1960

The CAS Administrative Board reviewed the possible studies proposed based on the 469 Longitudinal Study physicians who have entered academic medicine. Dr. Swanson expanded somewhat on the material in the agenda.

None of the Board expressed any particular enthusiasm for or opposition to the generation of data as outlined. Dr. Cole did comment that due to the time interval (1960-1975) one needed to keep in mind that one was "measuring with a rubber band." Dr. Swanson remarked that that was one of the problems with any longitudinal research.

F. Nominating Committee

The problem of the CAS' having elected at the Fall Meeting an individual to the Nominating Committee who, it was later discovered, was ineligible to run for election since he was no longer an official representative, was raised. The Board

decided that the seat should be filled by the individual next in line who had received the most votes. (NOTE: A later reexamination of the ballots cast disclosed the the seat would go to Dr. Leslie Webster, who was duly notified.)

G. Society Representation at CAS Meetings

ACTION: Based on the analysis of attendance by official representatives of member societies since the February 1972 meeting, the CAS Administrative Board unanimously agreed that these records should be verified with the societies, that societies consistently unrepresented at meetings should be polled as to the reason for their absence and with concern that information about the programs of the Council and of the AAMC may not be reaching them. Further, societies consistently being represented at meetings should be encouraged to continue their participation.

H. Academic Anesthesia Chairmen Resolution

The Board received a copy of the report on which the Academic Anesthesia Chairmen Resolution (considered at the last Board meeting) had been based. Submitted September 1974 by an ASA Subcommittee on the Task Force on Academic Anesthesia Manpower, this report contains both the results of a survey of academic anesthesiology (9 pages) and recommendations for anesthesia faculty (9 pages). Dr. John E. Steinhaus chaired the study group.

It was felt that data could be generated through the AAMC Faculty Roster that would be useful to this and other groups undertaking similar efforts.

I. Other Information Items

Other information items that were received by the CAS Administrative Board included:

1. Resolutions Received from American Academy of Orthopaedic Surgeons on:
 - a. GAP Report
 - b. AAMC FMG Task Force Report
 - c. CCME Primary Care Physician Report
2. 1974-75 Roster of CCME, LCGME and LCME Members
3. 1974-75 Roster of AAMC Groups - Steering Committee Members
4. Future Meeting Dates

IV. Next CAS Administrative Board Meeting

ACTION: The CAS Administrative Board unanimously agreed that,

depending upon the availability of the AAMC President and Vice President, a retreat, beginning the evening of June 17 and concluding at noon on June 19, should be planned in conjunction with the next regularly scheduled meeting. The purpose of this meeting is to review the development and progress of the Council of Academic Societies with particular emphasis on assessing its future goals and priorities.

V. Adjournment

The formal meeting was adjourned at 12:50 p.m. in time for a joint luncheon with the Administrative Boards of the other two Councils. The business meeting of the Executive Council followed. An executive session of the Executive Council with members of the President's Biomedical Research Panel was held the following morning, April 4.

ADDENDUM to Item D, paragraph 4, on page 11; from Weekly Activities Report #75-15:

"PAUL MARKS' VIEWS ARE CLARIFIED: Paul Marks, Vice President for Health Sciences at Columbia University and a member of the President's Biomedical Research Panel, has informed me that the statement in the Weekly Activities Report #75-13 misrepresents his views about the appropriate locus for the Nation's biomedical research efforts. Doctor Marks says, "I feel strongly that the future productivity of biomedical research in this country depends on its continuing to be a major commitment in our medical schools. To disassociate biomedical research from our educational and training efforts would be nothing less than disastrous to the quality of both biomedical research and education." As an individual, he also feels "that those of us in academic health centers cannot rest complacently on our past achievements. We must continue to structure our programs so that medical schools and universities will continue to be institutions where excellence in biomedical research can be achieved." We are sorry that his remarks at the CAS meeting were misinterpreted and are happy to clarify his position in this important matter.

MHL/kb
4-18-75 (Rev.)

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MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Mignon Sample

NAME OF SOCIETY: The Society for Gynecologic Investigation

MAILING ADDRESS: c/o Thomas H. Kirschbaum, M.D., Secretary-Treasurer
Department of Obstetrics and Gynecology
178 Giltner Hall
Michigan State University
East Lansing, Michigan 48824

PURPOSE:

To stimulate, encourage, assist, and conduct fundamental gynecic research, to provide opportunities for investigators in obstetrics and gynecology to enter into free exchange of ideas to the end of increasing knowledge and techniques in these fields.

MEMBERSHIP CRITERIA: Less than 46 years at initial membership, occupation of a responsible position in an institution of higher learning for not less than two years, and demonstration of promise of a continuingly productive academic career based on recent and current investigative activity.

NUMBER OF MEMBERS: 245

NUMBER OF FACULTY MEMBERS: 245

DATE ORGANIZED: 1952

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

January 1975 1. Constitution & Bylaws

March 28, 1974 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

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

 X YES NO

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

 501(c)(3)

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

- X a. Approved by IRS (May 14, 1965)
- b. Denied by IRS
- c. Pending IRS determination

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

Thomas H. Kaselba
(Completed by - please sign)

12/12/74
(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Mignon Sample

NAME OF SOCIETY: The Educational Foundation of the American Society of
Plastic and Reconstructive Surgeons, Inc.
MAILING ADDRESS: 29 East Madison Street, Suite 807
Chicago, Illinois 60602

PURPOSE: See attached copy of the Educational Foundation Constitution,
Article II, Purposes

MEMBERSHIP CRITERIA: See attached copy of the American Society of Plastic
and Reconstructive Surgeons, Inc. Bylaws, Article III, Section I which includes
membership in the Educational Foundation.

NUMBER OF MEMBERS: 1,231 Voting Members

NUMBER OF FACULTY MEMBERS: Not Applicable

DATE ORGANIZED: 1947

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

Revised, 9/72 1. Constitution & Bylaws

1973 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

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

X YES NO

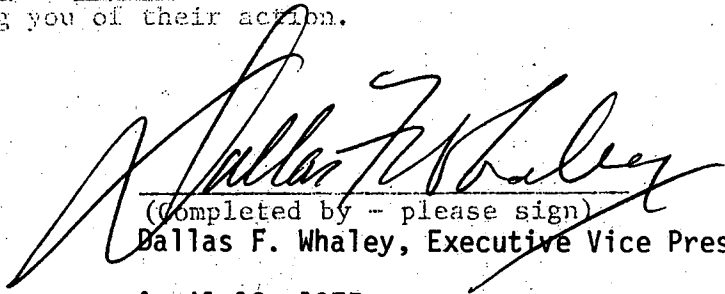
2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501 C3

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

- X a. Approved by IRS
 b. Denied by IRS
 c. Pending IRS determination

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


(Completed by - please sign)

Dallas F. Whaley, Executive Vice President

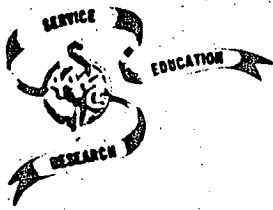
April 18, 1975

(Date)

ACADEMIC MEDICAL CENTER PROBLEM
IDENTIFICATION SURVEY

Attached is a draft of a survey of the Council of Deans being undertaken by the Division of Institutional Studies to identify problems in academic medical center governance. Round I is an open-ended request for contributions to an issues list. Round II will request that each issue be rated on several dimensions.

By copy of this memorandum the Administrative Boards of the CAS and the COTH are invited to evaluate this survey in terms of the potential interest of their Councils in participating in Round II of this survey.



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

June 9, 1975

DRAFT

M E M O R A N D U M

TO : Members of the Council of Deans
FROM : Joseph A. Keyes, Director, Division of Institutional Studies
SUBJECT: Delphoid Governance Issues Identification Survey

This is Round I of the survey to identify problems and issues in the organization, administration, management and governance of the medical school/academic medical center. You will recall that this survey was discussed at the spring meeting of the Council and endorsed by the deans at that meeting.^{1/}

The format of this survey will be similar to that employed in last year's Delphi Forecast of the Future of Medical Education. That is, we will commence with this, an open-ended first round soliciting individual responses of key issue areas. This will be followed by one or more rounds which will request that you rate the significance of issues on a composite list derived from round I on several dimensions. Our target is to report the results of this study to the Council meeting in November and to use the results as input to the program planning for next year's spring meeting.

In this round, we are asking you to perform two discrete tasks. The first is to contribute to the issue list. The second is to verify or correct our classification of your institution: organizational structure, components of the medical center and institutional characteristics.

^{1/}Further details regarding the background of the survey and the deliberations leading to the decision to undertake a study of this nature are contained in the agenda book for the Council's April 30 meeting and in the minutes of the COD Administrative Board meetings of January 15 and April 3, 1975.

Please return your responses to both questionnaires in the envelope supplied by _____.

Thank you for your cooperation.

Round I Questionnaire

List five key problems or issues which your institution faces or expects to face in the near future in the area of medical school/medical center organization/administration/management/governance. In considering your response take the broadest latitude in interpreting the scope of this inquiry. For example, you may wish to indicate problems in the area of administrative structure (e.g. role definition of dean, hospital director and university vice president), faculty organization and governance, relationship of components within the medical center, relationship to the university or relationship to affiliated hospitals. Please describe the problem with a level of specificity which would permit another institution to judge whether it shared a common concern.

1. _____

2. _____

3. _____

4. _____

5. _____

Name _____
School _____

Round II

List of Issues

Questions about issues

1. 2. 3. 4. 5.

1.

2.

3.

4.

5.

Questions

1. Is this a problem in your institution? (yes or no)

2. If no, it is not now a problem because:

A. It has been solved successfully

B. It has never arisen

C. It is not applicable to our situation

D. It is a problem - see #1

3. Though it has never arisen:

A. We are confident that we are prepared to handle it.

B. We are probably fairly vulnerable and would require
either substantial insitutional work or outside
assistance to solve it should it arise.

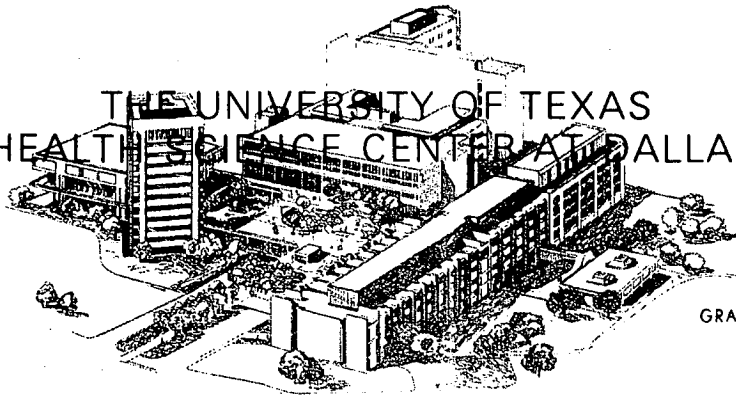
4. Irrespective of whether or not this is now a problem, how
would you rate the significance of this issue to academic medicine?

(1=No importance, 5=Extremely important) 1 2 3 4 5

5. With respect to this issue, what would you judge to be the most appropriate role of the AAMC?

- A. No Role
- B. Keep track of national level developments
- C. Gather data on current institutional practices
- D. Undertake analytical studies
- E. Provide a forum for discussion
- F. Formulate public positions

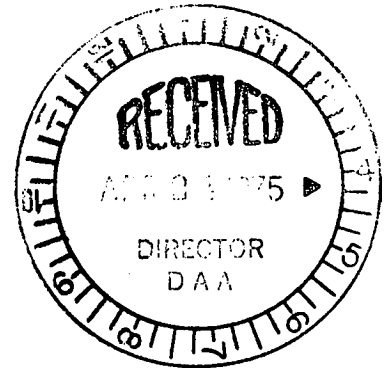
THE UNIVERSITY OF TEXAS
HEALTH SCIENCE CENTER AT DALLAS



R. W. ESTABROOK, Ph D
VIRGINIA LAZENBY O'HARA PROFESSOR
CHAIRMAN, BIOCHEMISTRY DEPARTMENT

SOUTHWESTERN MEDICAL SCHOOL
GRADUATE SCHOOL OF BIOMEDICAL SCIENCES
SCHOOL OF ALLIED HEALTH SCIENCES

April 21, 1975



Dr. August Swanson
AAMC
Suite 200, One Dupont Circle
N. W. Washington, D.C. 20036

Dear Gus:

I am reviewing some of my earlier notes and I have listed the need to write you asking that the Administrative Board of the CAS consider the convening of the CAS spring meeting for 1976 in Philadelphia together with the proposed International Conference scheduled by the National Board of Medical Examiners. I can see many advantages to members of the CAS to meet together with this group so that they may become better informed on the changes of evaluation of students that are proposed. I would appreciate your including this as an agenda item at the next Administrative Board meeting for the CAS.

Sincerely yours,

RONALD W. ESTABROOK, Ph.D.
Virginia Lazenby O'Hara Professor
Chairman of Biochemistry

RWE/mja

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MINUTES
CAS NOMINATING COMMITTEE
MEETING

May 15, 1975
Washington, D.C.

PRESENT: Committee Members

Jack W. Cole, M.D., Chairman
G.W.N. Eggers, M.D.
Daniel X. Freedman, M.D.
William L. Parry, M.D.
Leslie T. Webster, M.D.

Staff

Mary H. Littlemeyer
Mignon M. Sample

ABSENT: Committee Members

Carmine D. Clemente, Ph.D.
James B. Preston, M.D.

The CAS Nominating Committee convened at AAMC Headquarters at 10:00 a.m. to select the slate to be presented at the fall CAS Business Meeting. Suggestions were received prior to the meeting from Dr. Clemente, who was unable to attend the meeting.

The slate to be developed included the Chairman-Elect and two Board members from the Clinical Sciences and three Board members from the Basic Sciences for six vacancies. For each vacancy to be filled, two individuals were designated with alternates in the event that one would be needed. Before the nominations could be finalized, the willingness of the potential nominees to stand for election would be determined. Also, the academic society involved must agree that for the duration of the individual's term of office on the CAS Board, he or she would be appointed or would continue to serve as an official representative of that society.

Potential nominees were chosen from among the official representatives and the officers of the 58 member academic societies. They were nominated on the basis of their stature, their special areas of interest, and the disciplines and societies they represent. Wherever possible, an attempt was also made to effect a balance among the medical schools with various geographical sections of the country represented.

Before the meeting adjourned at 2:00 p.m. the willingness of one individual to stand for Chairman-Elect (Dr. Eugene Braunwald) had been established. Dr. Jay Bollet could not be contacted until later.

The recommendation of the CAS Nominating Committee to the AAMC Nominating Committee for Chairman-Elect of the Assembly is Ivan L. Bennett, Jr., M.D., Chairman, Council of Deans.

Minutes - May 15, 1975
CAS Nominating Committee
Page Two

The attached slate was chosen:

PROPOSED SLATE
CAS ADMINISTRATIVE BOARD
1975-76

CHAIRMAN-ELECT

(From the Clinical Sciences, One to be selected)

1. Eugene Braunwald, M.D., President, American Society for Clinical Investigation, (Term expires May 1975) Peter Bent Brigham Hospital
2. A. J. Bollet, M.D., Official Representative, Association of American Physicians, (Term expires May 1975), SUNY Downstate, Medicine

CLINICAL SCIENCES

(Four to run for two Board vacancies)

1. Daniel Freedman, M.D., Official Representative, American Association of Chairmen of Depts. of Psychiatry, (Term Indefinite), University of Chicago, Department of Psychiatry
2. Philip R. Dodge, M.D., President, Association of Medical School Pediatric Department Chairmen, Inc. (Term expires January 1977), Washington University, Department of Pediatrics
3. James F. Glenn, M.D., Official Representative, Society of University Urologists, (Term expires November 1977), Duke, Division of Urologic Surgery
4. Hiram C. Polk, Jr., M.D., Official Representative, Association for Academic Surgery, (Term expires November 1975), University of Louisville, Department of Surgery

Alternates

1. Gene H. Stollerman, M.D., Official Representative, Central Society for Clinical Research, (Term expires November 1975), University of Tennessee, Department of Medicine
2. Irwin M. Arias, M.D., President-Elect, American Association for the Study of Liver Disease, (Term expires November 1975), Albert Einstein, Department of Medicine

Minutes - May 15, 1975
CAS Nominating Committee
Page Three

BASIC SCIENCES

(Six to run for three Board vacancies)

1. Leslie T. Webster, M.D., Official Representative, Association for Medical School Pharmacology, (Term Indefinite), Northwestern, Department of Pharmacology
2. Carmine D. Clemente, Ph.D., President-Elect, American Association of Anatomists, (Term Expires April 1976), UCLA, Department of Anatomy
3. Paul Berg, Ph.D., President, American Society of Biological Chemists, Inc., (Term expires April 1976), Stanford, Dept. of Biochemistry

Alternates for Dr. Berg

- a) Earl Davie, Ph.D., President-Elect, American Society of Biological Chemists, Inc., (Term expires April 1976), University of Washington, Department of Biochemistry
- b) William J. Rutter, Ph.D., Treasurer, American Society of Biological Chemists, Inc., (Term expires June 1976), UCSF, Biochemistry
4. Harold S. Ginsberg, M.D., Association of Medical School Microbiology Chairmen, Columbia P & S, Department of Microbiology
5. Donald West King, Jr., M.D., President, American Association of Pathologists and Bacteriologists, (Term expires June 1975), Columbia P & S, Department of Pathology
6. Thomas H. Maren, M.D., Association for Medical School Pharmacology, University of Florida, Department of Pharmacology & Therapeutics

1975
MEETING DATES

CAS Administrative Board Meeting
Washington, D.C.
8:30 a.m. - 4:00 p.m.

September 18, 1975

AAMC ANNUAL MEETING
Washington Hilton Hotel
Washington, D.C.

November 2 - 6, 1975

AAMC ANNUAL MEETING SCHEDULE

November 2-6, 1975
Washington Hilton Hotel

"Excellence in Medicine: The Role of Medical Education"

	SUN	MON	TUES	WED	THURS
AM	Misc. Societies Other Misc.	Council Meetings Group Mtgs Other Misc.	PLENARY SESSION	PLENARY SESSION	Misc. Meetings Group Mtgs
PM	Misc. Societies Other Misc.	Council Meetings Group Mtgs. Other Misc.	ASSEMBLY	COUNCIL PROGRAMS Other Misc.	Misc. Meetings Group Mtgs

JOINT CAS/COD/COTH Meeting: Wednesday, November 5, 1975 2:30 - 5:00 p.m.

"Maximum Disclosure: Individual Rights and Institutional Needs"

P R O P O S E D
B A L L O T

COUNCIL OF ACADEMIC SOCIETIES

1974-1975

Administrative Board Positions

Administrative Board

For Chairman-Elect,

VOTE FOR ONE:

Confirmed

BOLLET, A.J., M.D.

(Association of American Physicians
Department of Medicine, SUNY Downstate)

Confirmed

BRAUNWALD, Eugene, M.D.

(American Society for Clinical Inves-
tigation, Dept. of Medicine, Peter
Bent Brigham Hospital)

PROPOSED
BALLOT

- 2 -

For Administrative Board,

VOTE FOR TWO:

DODGE, Philip R., M.D.

(Association of Medical School
Pediatric Dept. Chairmen, Washington U.)

Confirmed

FREEDMAN, Daniel, M.D.

(American Association of Chairmen of
Dept. of Psychiatry, U. of Chicago)

Confirmed

GLENN, James F., M.D.

(Society of University Urologists,
Div. of Urologic Surgery, Duke)

Confirmed

POLK, Hiram C., Jr., M.D.

(Association for Academic Surgery,
Dept. of Surgery, U. of Louisville)

PROPOSED
BALLOT

- 3 -

For Administrative Board, Basic Science Representatives

VOTE FOR THREE:

<i>Declined</i>	BERG, Paul, Ph.D.	<u>(American Society of Biological Chemists, Stanford)</u>
<i>Confirmed</i>	CLEMENTE, Carmine D., Ph.D.	<u>(American Association of Anatomists UCLA, Dept. of Anatomy)</u>
<i>Confirmed</i>	GINSBERG, Harold S., M.D.	<u>(Association of Medical School Microbiology Chairmen, Columbia P&S)</u>
<i>Confirmed</i>	KING, Donald West, Jr., M.D.	<u>(American Association of Pathologists and Bacteriologists, Columbia P&S)</u>
<i>Confirmed</i>	MAREN, Thomas H., M.D.	<u>(Association for Medical School Pharmacology, U. of Florida)</u>
<i>Confirmed</i>	WEBSTER, Leslie T., M.D.	<u>(Association for Medical School Pharmacology, Northwestern U.)</u>

(1)

COMMITTEE RECOMMENDED PREAMBLE

The United States as a matter of public policy should recognize the essentiality for the education and training of sufficient physician manpower to provide adequately for the medical services of its citizens. The education and training of the required physician manpower for this country will provide the public with physicians education and trained in the social milieu of this country and with a high degree of medical knowledge obtained in its excellent medical schools and the health care institutions which provide accredited programs in graduate medical education.

LCGME/CCME Recommendation #1

For the purpose of reimbursement under National Health Insurance, the cost of approved programs of graduate medical education in teaching institutions shall be included in the overall "cost of doing business." The cost of graduate medical education shall not be divided into cost for service, cost for education, and cost for teaching. The "cost of going business" shall include the recompense of residents, payment to supervisors and teachers, and cost of facilities, including space and equipment.

Review Committee Recommendation

For purposes of reimbursement under national health insurance the costs of approved programs of clinical post-doctoral education in teaching institutions shall be included as an allowable cost (a cost of doing business). The allowable costs of graduate medical education include, but are not limited to, the recompense of clinical post-doctoral trainees (interns, residents and fellows), payments to supervisors and teachers, and are applicable to both inpatient and outpatient services as well as the cost of space, equipment and supplies. Revenue from grants, endowments and other available sources applicable to clinical post-doctoral medical education should be deducted from total cost prior to determining reimbursable cost. The manner and amount of compensation for clinical post-doctoral trainees should be left to local option.

LCGME/CCME Recommendation #2

Graduate medical education in all its aspects shall be provided for within health insurance premiums.

Review Committee Recommendation

The recognition of the costs of approved programs in clinical post-doctoral education as an allowable cost shall be acknowledged and paid by all purchasers of health care services whether governmental or private.

LCGME/CCME Recommendation #3

All individuals (defined as residents and clinical fellows providing patient care) involved in graduate medical education shall be considered part of the medical staff of the teaching institution under the bylaws, rules and regulations of that institution.

Review Committee Recommendation

This recommendation should be withdrawn.

LCGME/CCME Recommendation #4

The manner in which residents are paid shall be left to local option. Options may include:

- (a) Payment of stipend or salaries to residents within hospital budgets;
- (b) Payment to residents, out of fees earned for direct service to patients in accordance with the participation of residents in the practice plan of the teaching institutions.

Review Committee Recommendation

The final two sentences of substitute recommendation #1 serve the purpose of this statement. Therefore, it should be deleted.

LCGME/CCME Recommendation #5

A national health insurance system should provide support for research and development of programs in graduate medical education.

Review Committee Recommendation

This recommendation should be deleted since it is included in the following recommendation.

LCGME/CCME Recommendation #6

A national health insurance system should provide support for modification of programs in graduate medical education through the appropriate expansion of existing programs, the addition of needed new programs, or the elimination of programs which no longer fit the aims of education or needs of patient care.

Review Committee Recommendation

A national health insurance system should provide support for modification of programs in clinical post-doctoral medical education through the appropriate expansion of existing programs, the development and addition of needed innovative programs, and should facilitate the elimination of programs which no longer fulfill the aims of education or needs of patient care.

LCGME/CCME Recommendation #7

Any system of national health insurance should provide for ambulatory patient care. The recommendations 1-6 shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of graduate medical education in the ambulatory setting, including facilities, space and equipment.

Review Committee Recommendation

Any system of national health insurance should provide for and encourage clinical post-doctoral education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of clinical post-doctoral education in the ambulatory setting, including facilities, space and equipment as well as personnel.

REPORT OF THE
NATIONAL HEALTH INSURANCE REVIEW COMMITTEE

The Committee reviewed the recommendations of the CCME/LCGME Committee on National Health Insurance and recommends the modifications itemized in the attachment to this report.

Also, the Committee reviewed the Report of the AAMC Task Force on National Health Insurance and reaffirms the desirability of its many recommendations. The Committee wishes to specifically emphasize the importance of the Task Force's recommendations concerning reimbursement of teaching hospitals and philanthropy as being of particular and critical importance to academic medical centers. The Committee believes that the attached recommended modifications of the CCME/- LCGME recommendations and the AAMC Task Force recommendations regarding reimbursement of teaching hospitals and philanthropy, with wording revised for purposes of continuity, directly and succinctly address the National Health Insurance issues with which the AAMC is most concerned.

The revised wording of the Task Force Report recommended by the Committee is:

"In addition to the foregoing educational issues, the inclusion of the following provisions in any National Health Insurance Program is especially critical to the maintenance of the excellence of the nation's academic medical centers:

- (1) The reimbursement policies must reflect that there are valid differences among the various types of providers in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; (2) the comprehensiveness and intensity of services provided by the teaching hospital; and (3) the teaching hospital's commitment to the incremental costs of providing the environment for medical and paramedical educational programs.

- (2) Philanthropy must be encouraged and its importance to the health care system recognized. Philanthropic contributions have provided non-profit and public hospitals with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and for innovative programs. This vital support has stimulated research and development in medical care organization. More specifically, the tax system should continue to provide deductions from corporate and individual income taxes for charitable contributions. Second, hospital reimbursement formulas should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. Finally, expenditures of funds derived from philanthropy should be under the control of the Governing Body of the respective hospital subject only to the approval of authorized planning agencies."

The Committee believes that its recommended modifications of the CCME/LCGME recommendations and the above statement, taken together, should constitute the essentials of AAMC policy in regard to National Health Insurance. It also believes that they should form the basis for a response to Representative Rogers' letter to Dr. John Cooper of June 2, seeking the AAMC's views regarding National Health Insurance goals.

Respectfully submitted,

Charles B. Womer, Chairman
Robert Buchancn, M.D.
Thomas R. Johns II, M.D.
David D. Thompson, M.D.
Phil Zakowski

PREAMBLE

The United States as a matter of public policy should recognize the essentiality for the education and training of sufficient physician manpower to provide adequately for the medical services of its citizens. The education and training of the required physician manpower for this country will provide the public with physicians educated and trained in the social milieu of this country and with a high degree of medical knowledge obtained in its excellent medical schools and the health care institutions which provide accredited programs in graduate medical education.

- (1) For purpose of reimbursement under national health insurance the costs of approved programs of clinical post-doctoral education in teaching institutions shall be included as an allowable cost (a cost of doing business). The allowable costs of graduate medical education include, but are not limited to, the recompense of clinical post-doctoral trainees (interns, residents and fellows), payments to supervisors and teachers, and are applicable to both inpatient and outpatient services as well as the cost of space, equipment and supplies. Revenue from grants, endowments and other available sources applicable to clinical post-doctoral medical education should be deducted from total cost prior to determining reimbursement cost. The manner and amount of compensation for clinical post-doctoral trainees should be left to local option.
- (2) Any system of national health insurance should provide for and encourage clinical post-doctoral education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of clinical post-doctoral education in the ambulatory setting, including facilities, space and equipment as well as personnel.
- (3) The recognition of the costs of approved programs in clinical post-doctoral education as an allowable cost shall be acknowledged and paid by all purchasers of health care services whether governmental or private.
- (4) A national health insurance system should provide support for modification of programs in clinical post-doctoral medical education through the appropriate expansion of existing programs, the addition of needed new programs, or the elimination of programs which no longer fit the aims of education or needs of patient care.