

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 23, 1976

5:00 p.m.	Business Meeting	<i>Bancroft Room Washington Hilton</i>
6:30 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Dinner	<i>Monroe Room</i>

Guest: *Theodore Cooper, M.D.,  
Assistant Secretary for Health*

June 24, 1976

8:00 a.m.	Business Meeting <i>(Coffee and Danish)</i>	<i>Farragut Room</i>
11:30 a.m.	Joint CAS/COD Discussion	<i>Hamilton Room</i>
1:30 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon	<i>Hemisphere Room</i>
	Executive Council Business Meeting	
4:00 p.m.	Adjourn	

FUTURE MEETING DATES

1976

CAS Administrative Board	Washington, D.C.	September 15-16
AAMC Annual Meeting	San Francisco	November 11-15
AAMC Officers Retreat	Baltimore, MD	December 15-17

1977

CAS Administrative Board	Washington, D.C.	January 12-13
		March 30-31
		June 22-23
		September 14-15
AAMC Annual Meeting	Washington, D.C.	November 5-10

AGENDA  
COUNCIL OF ACADEMIC SOCIETIES  
ADMINISTRATIVE BOARD

June 23-24, 1976

I. REPORT OF THE CHAIRMAN

II. ACTION ITEMS\*\*

1. Approval of Minutes of CAS Administrative Board Meeting . . . . . 1  
of March 24-25, 1976
2. All Action Items in Executive Council Agenda - With  
Particular Attention To:
  - Report of the President's Biomedical Research  
Panel - Analysis and Comment
  - Review and Response to the IOM Social Securities  
Studies
  - LCME Guidelines for Functions & Structures of A  
Medical School
  - Report of the Committee on Governance and Structure

III. DISCUSSION ITEMS\*\*

1. Joint Board Meeting with Assistant Secretary for Health - . . . . . 12  
Dr. Theodore Cooper
2. Planning for a Legislative Workshop
3. Annual Meeting Program Plans . . . . . 13
4. Joint CAS/COD Discussion - "Accreditation in Medicine - . . . . . 18  
*Role, Functions & Challenges*"

IV. INFORMATION ITEMS

1. Withdrawal of Biophysical Society . . . . . 58
2. Letters Received Commenting on CAS Brief . . . . . 61

\*\*See Order of Business (next page)

## ORDER OF BUSINESS

### Wednesday, June 23

5:00 p.m. - 6:30 p.m.

- Review and Response to IOM Social Securities Studies
- Miscellaneous Minor Items from Executive Council Agenda
- Briefing on ad hoc Committee Meeting in Preparation for Meeting with Dr. Cooper

### Thursday, June 24

8:00 a.m. - Response to President's Biomedical Research Panel Report

9:00 a.m. - Governance and Structure Committee Report

9:30 a.m. - Legislative Workshop Planning

10:00 a.m. - Annual Meeting Program Plans

10:45 a.m. - LCME Guidelines

11:30 a.m. - Joint CAS/COD Meeting on Accreditation

1:00 p.m. - Joint Board Luncheon and Executive Council Meeting

4:00 p.m. - Adjourn

MINUTES  
ADMINISTRATIVE BOARD  
COUNCIL OF ACADEMIC SOCIETIES

March 24-25, 1976

Washington Hilton Hotel  
Washington, D.C.

PRESENT: Board Members

Rolla B. Hill  
Chairman (Presiding)  
Robert M. Berne  
F. Marion Bishop  
Carmine D. Clemente  
Jack W. Cole  
Philip R. Dodge  
Daniel X. Freedman  
Thomas K. Oliver, Jr.\*  
Robert G. Petersdorf\*\*  
Leslie T. Webster

Staff

Judy Braslow\*  
John A.D. Cooper\*  
James B. Erdmann\*  
Mary H. Littlemeyer  
Thomas E. Morgan  
Mignon Sample  
John F. Sherman\*  
August G. Swanson

ABSENT: A. Jay Bollet  
Donald W. King

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting of January 13-14, 1976, were adopted as circulated.

II. Action Items

A. Ratification of LCME Accreditation Decisions

The CAS Administrative Board expressed a number of continuing concerns about the accreditation process in undergraduate medical education. To begin, Dr. Swanson explained the difference between a Letter of Reasonable Assurance (LRA) and Provisional accreditation. The latter is automatic from the time a school enters its first class until it graduates its first class (See "Procedures Leading to Provisional Accreditation of New Medical Schools"--Attachment A). When a school receives a LRA, it has no accreditation status (See Attachment B).

Among the questions the CAS Administrative Board raised were:

- When was a school ever disaccredited?
- Why was the stipulation adopted that would preclude
- Why was the stipulation adopted that would preclude any but those who had been on LCME in the past being included on the LCME Appeals Panel?
- Why have site visits not included new visitors?

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

Questions asked on a recent site visit were described as "totally inappropriate." There was a general feeling (among the faculty) that the questioning was "not of a good quality. It was a weak group." Why?

What is the role of the CAS in accreditation?

How can you educate the site visitors first as to what your objectives are and second as to how you intend to fulfill them?

Do the site visitors take into account nontraditional models in undergraduate medical schools? One recent site visiting team was described as having "very little understanding or even interest in what we as a different kind of a medical school are trying to do."

An overriding concern was that the CAS Administrative Board had been ratifying accreditation decisions of the LCME without sufficient information to enable them to make an intelligent decision. Dr. Swanson reminded the Board that CAS Board Members who are on the Executive Council receive complete accreditation information and could be alerted to be prepared to answer questions at future meetings.

In view of these several areas of concern, most particularly in the role of the CAS in the accreditation process, it was the hope of the CAS Administrative Board that James R. Schofield, M.D., Director of the AAMC Division of Accreditation, would join the Board for its June meeting at which time a special focus of the agenda could be accreditation in undergraduate medical education. Prior to that meeting it would be helpful if data could be made available such as:

How many institutions now are or have been (in the past 3-4 years) placed on probation? For what reasons?

For the same period of time, how many schools have been accredited and for what periods of time? In cases of accreditation for less than seven years, what are the reasons?

What has been (over the past 3-4 years) the composition of the accreditation teams? Indicate the distribution of faculty vs. administrators, geographic spread, number of site visitors that have been "first-timers."

Dr. Swanson will extend an invitation to Dr. Schofield to meet with the CAS Administrative Board. A number of data provided by Dr. Schofield's office are attached as Attachment C.

One final note concluding this accreditation discussion was that the Board thought something like the Accreditation Pamphlet developed by the Organization of Student Representatives would be valuable to prepare faculty for a site visit.

ACTION: The CAS Administrative Board discussed at length accreditation in undergraduate medical education and expressed continuing concerns about the quality of both the process and the accrediting team. The Board took no action to ratify the LCME accreditation decisions but chose to request that Dr. James Schofield meet in June with the CAS Administrative Board to discuss this whole issue vis-a-vis the role of the CAS Administrative Board in the accreditation process. Additionally the CAS Administrative Board requested that data to provide information on the recent history of LCME actions be made available.

B. LCME Guidelines for Function and Structure of a Medical School

The CAS Administrative Board in general reacted negatively to this document. While at the meeting there was not time to do a line-by-line review of the "Guidelines," Dr. Webster who had studied it carefully before the meeting pointed out several problems he found with it as written. There was a consensus that the amount of detail provided could lead to a rigid, inflexible approach that would be anything but helpful. When one member suggested that a more general document would be preferred, Dr. Swanson explained that the purpose of the "Guidelines" was to provide specifics to back up the "Structure and Functions" Document. To acquaint the new members with this document and to refresh the memory of others, a copy of the basic accreditation document is attached to these minutes as Attachment D.

ACTION: After spending a considerable amount of time discussing a myriad of problems in this document, the CAS Administrative Board agreed to ask that the LCME defer action on it until the CAS Administrative Board had an opportunity for a more thorough study and critique of it.

NOTE: The Executive Council subsequently asked that the draft document be circulated to the Administrative Board for comment.

C. LCME Membership in the Council on Postsecondary Accreditation

The Council on Postsecondary Accreditation (COPA) is a national nonprofit organization whose major purpose is to support, coordinate, and improve all nongovernmental accrediting activities conducted at the postsecondary educational level in the United States. The LCME voted to join COPA for an annual membership fee of \$750.

ACTION: The CAS Administrative Board unanimously approved the recommendation that the Executive Council ratify the action of the LCME to join the Council on Postsecondary Accreditation for an annual fee of \$750.

D. Criteria for Corresponding Members

This was discussed at an earlier meeting of the Board. It is a classification of membership that has been developed to accommodate

community hospitals which do not qualify for membership in the Council of Teaching Hospitals. It will provide an opportunity for them to receive AAMC mailings.

ACTION: The CAS Administrative Board unanimously approved the recommendation as set forth in the Executive Council Agenda (page 51) regarding criteria for Corresponding Members in the Association.

E. Report of the Task Force on Continuing Medical Education

Dr. Emanuel Suter, who was active as staff to the Task Force on Continuing Medical Education, started this discussion. The Task Force, he explained, was appointed largely as the result of the recommendation arising out of the special discussion on Continuing Medical Education the CAS Administrative Board held in connection with its September 1975 regularly scheduled Board Meeting. Its report deals first with problems, both external and internal, affecting continuing medical education; AAMC's role in continuing medical education; and mechanisms by which AAMC can carry out its role. The Board's discussion focused on the latter aspect, which included three major recommendations:

1. Creation of a Group on Continuing Medical Education;
2. Appointment of an ad hoc Committee on Continuing Medical Education to recommend to the Executive Council policies for promulgation at the national level; and
3. Assignment of Staff Resources to Continuing Medical Education Programs.

Dr. Suter discussed first items Nos. 2 and 3 above, with which the Board concurred. Regarding No. 3 there was essentially no discussion. Regarding No. 2 there was some discussion as to the advisability of appointing a Task Force on Continuing Medical Education rather than an ad hoc Committee. Dr. Cooper explained that he prefers the former.

Most of the discussion centered on recommendation No. 1, for the creation of a new AAMC Group on Continuing Medical Education (GCME). One disadvantage of creating a separate GCME was that its members would tend to be separated from the mainstream of education. Conversely a separate group would afford them greater visibility and they should be able to establish and accomplish their goals more quickly. Who would comprise such a group was discussed. Dr. Petersdorf said that he thought in the future, particularly with relicensure requirements, continuing medical education would have to be integrated into the faculty's normal pedagogical functions.

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NOTE: A number of the Board expressed interest in the membership of the Liaison Committee on Continuing Medical Education (LCCME). See Attachment E.



In creating such a group, it would likely consist of directors of continuing medical education programs.

The AAMC Group on Medical Education (GME) was organized four years ago. It represents five areas of responsibility or special interest:

- Research in medical education
- Biomedical communications
- Undergraduate medical education
- Graduate medical education
- Continuing medical education.

The latter two were added approximately one year ago. As currently organized the GME Steering Committee (See Attachment F) does not include anyone whose major area is continuing medical education. It was suggested that if this were done, the continuing medical education interests might feel they had a voice in the GME.

Dr. Swanson pointed out that the establishment of a new group would have significant implications for the overall structure of the AAMC and would, therefore, be a recommendation that would have to be forwarded to the AAMC Standing Committee on Governance and Structure, which is chaired by D. C. Tosteson, M.D.

At Dr. Hill's request, Dr. Clemente, who served as a member of the Task Force on Continuing Medical Education, drafted a substitute to Recommendation No. 1. The CAS Administrative Board considered and adopted this substitute Recommendation which is reflected in the following action:

ACTION: The CAS Administrative Board unanimously approved Task Force recommendations Nos. 2 and 3 as set forth in the Executive Council Agenda (page 64). The CAS Administrative Board did not support the creation of a Group on Continuing Medical Education (Task Force recommendation No. 1). It adopted instead (as a substitute Recommendation No. 1) Broadening the Charge and Strengthening the Subsection on Continuing Medical Education of the Group on Medical Education. In recognition of the increasingly important role in Continuing Medical Education which will be undertaken by the faculty members of the nation's medical schools, it is recommended that the Subsection on Continuing Medical Education of the Group on Medical Education be strengthened in order to 1) serve as a national and regional forum for review of issues confronting faculties engaged in continuing medical education; 2) serve as liaison between AAMC staff and constituents; 3) alert the Association to areas in need of further review; and 4) integrate continuing medical education programs with the other two phases of the continuum of medical education.

To accomplish these tasks, the Subsection on Continuing Medical Education should be composed of directors of Continuing Medical Education programs at medical schools and should organize regional and national programs. To promote the concept of an educational continuum and to insure the proper involvement of CME personnel in the activities and programs of the GME, it is recommended that the rules determining the composition of the GME Steering Committee be modified to provide for the formal representation of the interests of the directors of CME within our member schools.

### III. Recess

The CAS Administrative Board recessed at 8:00 p.m. for cocktails and dinner. Mr. Steve Lawton, Counsel of the House Subcommittee on Public Health and Environment, who joined the Board at this time. After dinner Mr. Lawton spoke to the Board about several items of major interest including the Clinical Laboratory Improvement Act. Mr. Lawton indicated that prior to the efforts of Dr. Thomas Morgan no one was aware of the enormous implications the legislation as proposed had for biomedical research in the academic medical centers. He said that largely due to Dr. Morgan's efforts this would be dealt with and would pose no threat to the academic medical centers. A second area that Mr. Lawton addressed had to do with the current problems of the Food and Drug Administration. The final topic on which there was considerable discussion, was the problem of specialty and geographic distribution of physicians. There seemed to be more agreement between the Board and Mr. Lawton on the nature of the problem than there was on the nature of the solution.

The evening session of the meeting was concluded at 11:25 p.m.

### IV. Reconvene

The CAS Administrative Board reconvened at 8:30 a.m. on March 26.

#### F. The Academic Community and the Food and Drug Administration

Opening its morning session, the Board took action on the matter of the academic community and the Food and Drug Administration.

ACTION: The CAS Administrative Board took no action on the policy proposed in the CAS Administrative Board Agenda (page 20). There was a consensus that the AAMC should stay informed of developments in this and that the members of the CAS constituent societies should be advised that, to the extent that it is feasible resources of AAMC staff will be available to them to support their individual efforts.

#### G. Accreditation of Graduate Medical Education

Dr. James Pittman, guest of the CAS Administrative Board as Chairman of the Liaison Committee on Graduate Medical Education (LCGME), joined the CAS Administrative Board to discuss this topic.

Beginning this discussion, Dr. Pittman described step-by-step the process from the point of application for accreditation of a residency program to review by the Residency Review Committee and a subsequent review (the "re-review") by the LCGME. Several of the Board voiced their frustrations with the Residency Review process. One member felt it was "held in almost uniform disdain" and said he thought that people would be willing to pay more if the quality of the process could be improved. Substantive issues are not addressed: Is a resident becoming competent in his specialty and if not, why not? Number of books in the library, how many beds in the hospital, how many nurses per floor were typical of questions that were asked.

Guidelines should be set for when a program is placed on probation and when it is disapproved. The RRC must be encouraged to upgrade the programs they find to be weak.

The CAS can help by forwarding its suggestions to the LCGME, according to Dr. Swanson.

Two recurring themes throughout this discussion were that the quality of the site visits is unsatisfactory and that changing the process will be slow and labored due, in large part, to the A.M.A. control over it.

At the end of a lengthy session the Board took the following action:

- ACTION:
1. The Liaison Committee on Graduate Medical Education should review satisfactory programs less often than every three years, as is now the policy. The interval for such programs could be lengthened to seven years, as is the case with satisfactory undergraduate programs reviewed by the Liaison Committee on Medical Education.
  2. The Liaison Committee on Graduate Medical Education should provide more assistance to programs that do not meet acceptable standards.
  3. The Liaison Committee on Graduate Medical Education should improve both the format and the substance of the site visit.
  4. The Liaison Committee on Graduate Medical Education should obtain data regarding the experiences of other accreditation bodies with the U.S. Office of Education
  5. Ways of increasing the autonomy of the Liaison Committee on Graduate Medical Education should be explored including the possibility that the AAMC should offer to share staffing of the LCGME with the AMA and increasing charges to the programs.

6. Constituent societies of the Council of Academic Societies should be informed, either through a CAS Brief of some other vehicle, that they should forward in writing to Dr. Swanson any concerns they may have in this area.

H. Proposed CAS Legislative Workshop

Dr. Morgan reported that in a letter notifying the CAS of the cancellation of the spring meeting he asked for an expression of interest in the proposed legislative workshop. Seventy positive responses, representing 48 of the 60 societies, were received.

ACTION: The CAS Administrative Board was enthusiastic in its support of the proposed workshop and urged its continued development. Dates that will be explored are September 1976 or January 1977.

I. Biology Alliance for Public Affairs

There was considerable ambivalence within AAMC as to whether such an umbrella organization as this, yet another group on the national scene, could be effective. If it were to capture some real interest, an obvious advantage for AAMC to have a permanent seat on its executive committee could be seen. Nonetheless, the Board was able to control its enthusiasm about the creation of another umbrella organization.

ACTION: After weighing the advantages and the disadvantages of the proposal in the CAS Administrative Board Agenda (pages 16-17), the CAS Administrative Board unanimously disapproved the proposal with advice to resubmit if necessary.

J. Peer Review System of the National Institutes of Health

ACTION: Regarding the Peer Review System of the N.I.H., the CAS Administrative Board unanimously reaffirmed the "Present State of Policy Development" as set forth in the CAS Administrative Board Agenda (page 15).

K. Governmental Cognizance of the Institutional Well-Being of Academic Medical Centers

Dr. Morgan presented the background of this topic which was summarized in the Executive Council Agenda on pages 65-66. As one illustration of the absence of reality in federal planning, he cited the HEW's Forward Plan for Health which in its 300 or so pages did not once refer to the academic medical centers as the change agents but rather implied that the federal government in and of itself was going to accomplish these objectives. Attempts to educate various individuals on the federal scene, he felt, had

been fairly successful and had led to the recommendations proposed.

ACTION: The CAS Administrative Board supported the four possible courses of action enumerated in the Executive Council Agenda (page 66).

L. Institute of Medicine Social Security Study

The IOM Social Security Studies report entitled "Medicare-Medicaid Reimbursement Policies" was released on March 1. Copies of the report were distributed to the CAS Administrative Board prior to its meeting.

The studies were requested following intensive controversy over the 1973 proposed regulations implementing Section 227 of the 1972 Medicare Amendments. At that time the AAMC published an analysis of the fiscal and organizational impact the proposed regulations would have on six academic health centers.

Public Law 93-233 suspended the implementation of Section 227 until June 30, 1976 and directed the HEW Secretary to arrange for the conduct of a study concerning: A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVII and XIX of the Social Security Act in hospitals which have a teaching program; B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply; C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty; D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates; and E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the costs of salaries of interns and residents.

Among the more significant recommendations in the report are the following:

1. Section 227 of Public Law 92-603 should not go into effect on July 1, 1976. Until new legislation can be enacted and attendant regulations issued, Section 227 of Public Law 92-603 should be further suspended and authority to continue cost reimbursement for physician services under Section 15, Public Law 93-233 should be extended.
2. A fee-based method of payment is appropriate for teaching physicians only when they provide personal and identifiable services to program beneficiaries or directly supervise the provision of such services by house officers.... With one exception, the physician role test as described in the proposed Section 227 regulation is deemed appropriate as a test of whether personal and identifiable services are provided.

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The exception is the requirement for a pre-admission relationship between the physician and patient.... Under this method, after two years, no cost reimbursement would be allowed for supervisory and teaching services in teaching hospitals.

3. A unified method of payment is appropriate to institutions where there is a physician team approach to patient care and graduate medical education. Present knowledge and understanding of this method of payment suggest that it is responsible to the concerns of Congress and also appropriate to the ideals of graduate medical education. All services of licensed physicians (teaching physician and house officer) are paid out by Part B, except house officers who have not completed the first year of post-M.D./D.O. training (or second depending on state licensure requirements). Such house officers would be paid on a cost reimbursement basis to the hospital. The proposed conditions for this payment method limit its application to teaching institutions where there is a close relationship between teaching physician and house officer so that the conditions for personal and identifiable service are met by the team regardless of who actually performs the service.
4. Financing mechanisms should be changed to provide more equitable support for ambulatory care services so that medical school and teaching hospitals would find it easier financially to support primary care training programs.
5. A permanent quasi-public independent physician manpower commission of 13 members should be established by law to monitor the specialty distribution of physicians to determine the appropriate number of residency slots for each specialty.
6. With the exception of the category of contact defined as family practice, general internal medicine, and general pediatrics, the number of all other postgraduate specialty training slots available as of July 1, 1977, should be held at the level of residency positions filled as of July 1, 1975.
7. The study group recommends that Medicaid practices which pay physicians at lower levels in one geographic area than in another, particularly in underserved areas, be discontinued.
8. A detailed examination of Medicaid administrative practices should be undertaken to document the extent to which these practices affect the availability of physician services to underserved areas.
9. In view of the decreasing number of positions likely to be available for foreign medical graduates and the possibility that future foreign medical graduates may not be able to get the graduate medical education necessary for full

licensure in this country, the elimination of existing incentives for physician immigration is recommended, including the removal of medicine as a shortage profession under the Department of Labor's Schedule A.

V. Adjournment

The formal meeting was adjourned at 12:45 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.

MHL/mf  
4/12/76

Attachments (5)

JOINT BOARD MEETING WITH ASSISTANT SECRETARY FOR HEALTH

In April the AAMC staff met with Ted Cooper and his staff to discuss common problems and to emphasize the need for recognition of institutional stabilization in the accomplishment of federal health aims. At that time, Dr. Cooper said that he had two problems for which he needed help. The first is how to accomplish short-term cost containment for health services, and the second, how to reduce demand for health services in the long run. Subsequent to that meeting we invited Dr. Cooper to meet with the Executive Council and the Administrative Boards to discuss how the academic medical centers could work with the Assistant Secretary in solving these problems. An ad hoc committee composed of nine members met on June 10 in preparation for the meeting with Dr. Cooper. A report of the recommendations coming out of that meeting will be provided in advance of the Wednesday evening meeting.



## ANNUAL MEETING PROGRAM PLANS

At the last two Annual Meetings the Council of Academic Societies has jointly sponsored a session with COD and COTH. In 1974, the subject was on health manpower, particularly focusing on specialty distribution. In 1975, the subject was the effect of the various privacy and freedom of information acts on academic institutions. This year, the COD and COTH plan a joint session on the problems of large municipal hospitals. The CAS thus has an opportunity to have a program of its own. The time allotted for this will be on Friday afternoon, November 12. The CAS Business Meeting will be on Friday morning. It is always hard to anticipate how extensive the CAS Business Meeting will be. For several years, all business could be accomplished in one-half day. In 1974, when we reviewed the GAP report, we were barely able to finish our business in one day. Last year, the Business Meeting was slow and draggy and could have been accomplished in a shorter time. Therefore, it is recommended that the CAS develop a program attractive to its membership for Friday afternoon.

Major subject areas could be:

- 1) Research and Research Manpower
- 2) Graduate Medical Education and the Redistribution of Opportunities for Graduate Medical Education
- 3) Continuing Medical Education and its Impact on the Institutions
- 4) Medical Education and the Control of Demands for Health Services
- 5) Accreditation of Undergraduate and Graduate Medical Education

It is essential that at this meeting a decision be made regarding the subject to be covered in the Annual Meeting program so that a format may be established and speakers sought. Other ideas for the program topic will be welcome.

ANNUAL MEETING SCHEDULE

Wednesday, Nov. 10

Thursday, Nov. 11

Friday, Nov. 12

Saturday, Nov. 13

Sunday, Nov. 14

Monday, Nov. 15

-OSR Meetings

- Individual Societies

- OSR

- COD Program

- Individual Societies

- Council Meetings and Programs

- GSA Meetings

- CAS President's Breakfast

- Plenary Session

- Assembly

- RIME Conference

- Minority Affairs Program

- GME Meetings

- Plenary Session

- GME Meetings

- RIME Conference

- GSA Program

- Individual Societies

CAS ANNUAL MEETING, 1974

CAS ANNUAL MEETING, 1975

**CAS-COD-COTH JOINT MEETING**

WEDNESDAY, NOVEMBER 13

*International Ballroom*

Theme: SPECIALTY DISTRIBUTION OF PHYSICIANS

2:00 pm A Congressional Perception of the Problem  
*Stephan E. Lawton*

2:30 pm Redistribution of Specialty Training  
Opportunities—Options for the Private  
Sector  
*Arnold S. Relman, M.D.*

3:00 pm Redistribution of Specialty Training  
Opportunities—Options for the Govern-  
ment  
*Theodore Cooper, M.D.*

3:30 pm Break

3:50 pm Panel Discussion

Chairman: *Julius R. Krevans, M.D.*  
*Robert A. Chase, M.D.*  
*Charles B. Womer*  
*Christopher C. Fordham, M.D.*

**COD-CAS-COTH JOINT PROGRAM**

WEDNESDAY, NOVEMBER 3

*Ballroom Center*

2:00 pm

MAXIMUM DISCLOSURE: INDI-  
VIDUAL RIGHTS AND INSTI-  
TUTIONAL NEEDS

Speakers: *William Smith*  
*William P. Gerberding, Ph.D.*

Discussion

CAS ANNUAL MEETING, 1972

CAS ANNUAL MEETING, 1973

COD-CAS JOINT PROGRAM  
SUNDAY, NOVEMBER 5, 1972  
[F] Ballroom East

COUNCIL OF ACADEMIC SOCIETIES

SUNDAY, NOVEMBER 4  
Ballroom East

Theme: COLLEGES AND MEDICAL SCHOOLS  
— APPROACHES TO ACCOMPLISH-  
ING THEIR JOINT MISSION

10:00 am Business Meeting

9:00 am Introduction

2:00 pm General Session

9:05 am "Human Biology" — A New Under-  
graduate Major for the Liberal Arts  
*Bernard W. Nelson, M.D.*  
*Thomas B. Roos, Ph.D.*

Programs and Plans at the NIH  
*Robert S. Stone, M.D.*

9:25 am Discussion

2:45 pm Health Care in the Teaching Set-  
ting: The Impact of H.R. 1  
*Arnold S. Relman, M.D.*

9:40 am Direct Alignments of College Programs  
with Medical Schools  
*Ward W. Moore, Ph.D.*

3:30 pm Implications of the Reorganization  
of HEW for the University Health  
Center  
*Kenneth Endicott, M.D.*

10:00 am Discussion

4:15 pm A Discussion with John A. D.  
Cooper, M.D.

10:15 am Coffee

10:45 am Medical School Academic Entrance  
Requirements and the Realities of the  
Usual College Curriculum  
*Paul R. Elliott, Ph.D.*

MONDAY, NOVEMBER 5  
Ballroom Center

11:05 am Discussion

Theme: CERTAIN ETHICAL ASPECTS OF  
BIOMEDICAL RESEARCH

11:20 am Experiences with A.B.-M.D. Programs  
which Select Students for Medicine  
from High School or the First College  
Year  
*Gerald S. Kanter, Ph.D.*

Chairman: Robert G. Petersdorf, M.D.

11:40 am Discussion

2:00 pm Evolution of Concepts of Ethical  
Standards  
*James F. Toole, M.D.*

11:55 am Experiences with Encouraging Medical  
Students to Take Courses for Credit in  
Other Colleges in the University  
*Thomas E. Morgan, Jr., M.D.*

The Consequences of Over-Regula-  
tion of Clinical Research  
*Thomas C. Chalmers, M.D.*

12:15 pm Discussion

Some Practical Problems of Peer  
Review  
*Robert L. Levine, M.D.*

12:30 pm Adjournment

Non-Therapeutic Research on Chil-  
dren, An Ethical Dilemma  
*Charles U. Lowe, M.D.*

CAS ANNUAL MEETING, 1970

CAS ANNUAL MEETING, 1971

Friday, October 30  
Renaissance Room

- Theme: EDUCATION OF MANPOWER FOR  
PRIMARY HEALTH CARE
- Presiding: James V. Warren, M.D.
- 2:00 The Hospital's Needs for Primary Health Care  
Personnel  
H. Robert Cathcart, M.D.
- 2:15 Needs of the General Practitioner in an Urban  
Setting  
Joseph T. Ainsworth, M.D.
- 2:30 Needs from the Viewpoint of an Internist in an  
Urban, Non-Medical School Setting  
Donald E. Saunders, Jr., M.D.
- 2:45 Needs of a Large Pre-Paid Health Plan  
Eugene Vayda, M.D.
- 3:00 Needs of Federally Sponsored Community  
Health Centers  
Joyce Lashof, M.D.
- 3:15 Position of the Medical Schools  
James V. Warren, M.D.
- 3:45 Panel Discussion

Florentine Room

- 7:00 Committee on Biomedical Research Policy -  
Dinner

Saturday, October 31  
Music Room

- Presiding: D.C. Tosteson, M.D.
- 2:00 CAS General Session
- Preliminary Report & Recommendations  
Committee on Biomedical Research Policy  
Louis G. Welt, M.D.
- 3:30 CAS Business Meeting

COUNCIL OF ACADEMIC SOCIETIES

FRIDAY, OCTOBER 29

- Ballroom West*  
1:30 pm Joint Meeting With Group on Student  
Affairs and Research in Medical Educatio
- Theme: MEASURING THE EFFECTIVENESS  
OF PHYSICIAN PERFORMANCE
- Moderator: James V. Warren, M.D.
- Participants: George A. Goldberg, M.D.  
Beverly C. Payne, M.D.  
Sidney Shindell, M.D.  
Captain James C. Waugh

- Georgetown East*  
3:30 pm Business Meeting

- Crystal West*  
8:30 pm Open Faculty Forum

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JOINT CAS/COD DISCUSSION

"Accreditation in Medicine - Role, Functions & Challenges"

At the March meeting, there was considerable discussion surrounding the Liaison Committee on Medical Education and the accreditation process. The following materials provide information on the accreditation process as it has been conducted by the LCME. I particularly call your attention to the paper by Marjorie Wilson entitled, "Accreditation: Public Policy Nexus." On Thursday, June 24, we will meet with Tom Kinney and Steve Beering, who are members of the LCME for AAMC, and with Jim Schofield, who is Secretary to the LCME on alternate years. Dick Egan of the AMA staff, who is Secretary this year, may be here as well.

ACCREDITATION: PUBLIC POLICY NEXUS  
Marjorie P. Wilson, M.D.\*

HISTORY

The AAMC, first organized in 1876 and reorganized 1890, published its first list of member schools in 1896 and began inspection of the member schools in 1903. From the outset, membership in AAMC was based on compliance with established medical school standards. The organization adopted a resolution in 1876 which stipulated opposition to issuing diplomas without the graduate's name. Also, at that time a minimum standard for the medical course was established to consist of three courses of lectures, at least twenty weeks each. In 1877, the requirement that the medical course be three years in length was introduced. The latter requirement resulted in the dissolution of the original organization because so few medical schools were able to conform to the three-year standard, however, by 1890 there were sufficient numbers to reorganize.

During the late nineteenth century, there were virtually no legal restrictions to the establishment of medical schools and a variety of them developed, including those established primarily for the financial gain of the promoters and faculty, including "diploma mills" which sold diplomas with no pretense of providing medical training of any kind. As late as 1900 less than 10 percent of the practicing physicians were graduates of university-based medical schools, and only about 20 percent had ever attended lectures in medical schools. The majority were products of apprenticeships, and brief encounters with proprietary schools. Continuous concern by several organizations, including the AAMC and the American Medical Association, led to a few significant improvements toward the end of the century, such as specification of the content of the curriculum, the length of instruction and requirements for admission.

The first call for the organizational meeting of the American Medical Association in 1847 began with the statement: "It is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States." One of the first steps taken at the organizational meeting was the appointment of a committee on medical education which in 1904 was organized into the Council on Medical Education and Hospitals. The Council began inspecting medical schools in 1906, and until 1942 took independent action on the schools.

An outline of the history of the AAMC and AMA involvement in accreditation and the formation and activities of the LCME is attached as Appendix I. Early in this century the AMA took the initiative in encouraging the Carnegie Foundation for the Advancement of Teaching to sponsor a study of America's approach to medical education. Abraham Flexner was commissioned in 1908 to undertake a thorough study of the approximate 150 schools in existence at that time. The Flexner Report, published in 1910, was comprehensive and far-reaching and results were achieved promptly. The findings and recommendations

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focused on three concerns: (1) the urgent requirement of overall raising of standards in admissions and instructions, (2) the importance of relating medical education to the universities and placing it under their jurisdiction as a discipline controlled and correlated with the liberal arts and sciences, and (3) the need to provide full-time staff and facilities that would combine instruction and research in a setting that would offer experience in the laboratory and hospital as well as the lecture hall. The result of these efforts was primarily the elimination of weak proprietary schools which could not meet the requirements of new state laws and the merger or affiliation of other schools into stronger, single institutions. By 1927 there were only 80 schools of medicine in existence as compared to approximately 150 in existence in 1905.

During the period of 1934-1939 a representative from the Council on Medical Education and Hospitals of the AMA and a representative of the AAMC separately visited each medical school in the United States and Canada -- a total of 89 schools. On the basis of these visits, a profile of each teaching program was prepared and the strengths and weaknesses of each component of the program were reported to the parent organizations. Accrediting decisions, however, continued to be made separately by each organization in an uncoordinated fashion. The undesirable aspects of this disparity led to closer ties of these two organizations, and in 1942, the Liaison Committee on Medical Education and Hospitals was formed to develop a cooperative effort, concerted action, policy coordination, and combined site visits to the schools of medicine. Since that time, the combined efforts of these two national agencies has provided the continuing assurance that the interests of students, the profession, the academic institutions and society in the maintenance of sound medical education programs are protected by enforcing adherence to acceptable standards of quality.

#### PURPOSE OF ACCREDITATION

The official policy statement of the LCME, Functions and Structure of a Medical School, advises that the information contained therein is, "intended... 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."

The accreditation process provides for the medical schools a periodic, external review of assistance to their own efforts in maintaining the quality of their educational programs. Outside survey teams are able to focus on the areas of concern which are apparent, recommend other areas requiring increased attention, and indicate areas of strengths as well as weaknesses. In the recent



period of major enrollment expansion, the LCME has pointed out to certain schools that the limitation of their resources preclude expanding the enrollment without endangering the quality of the educational program. In yet other cases, it has encouraged schools to make more extensive use of their resources to expand their enrollments to meet public need. During the decade of the 60's particularly, the LCME encouraged and assisted in the development of new medical schools; on the other hand, it has cautioned against the admission of students before adequate and competent faculty is recruited, and the curriculum is sufficiently planned and developed and resources gathered for its implementation.

Since 1963 accreditation or reasonable assurance of accreditation has been a statutory prerequisite to eligibility for federal assistance for capital and later in 1965 for operating expenses.

Accreditation is related indirectly or directly with state licensing of physicians to practice. Twenty-five states require graduation from a program approved by the state licensing board, of these four permit explicit reliance on professional standards or lists prepared by national accrediting agencies. Four states require program approval by a state agency or official other than the licensing board and one state requires program approval by both the Board and the State Health Department. Ten require graduation from an approved program; of these only three make reference to accreditation; these specify approval based on educational standards required by a national professional accrediting agency; the seven remaining states leave the "approving" agency unspecified and in practice this is probably assumed by the licensing boards. The ten remaining states make specific mention of either the AAMC or the AMA in various combinations of one or the other, both, the licensing board and one or the other, or both, and the licensing board or both. Thus, there is no mention of the LCME as such, but seven make reference to it indirectly when specifying the national standards or national accrediting agency. Ten additional states specify the AMA and the AAMC with varying levels of delegated responsibility. Alaska is unique in specifying the "requirements of the Association of American Medical Colleges" as the standard.

Other aspects of the medical practice are based upon the accreditation by the LCME. For example, in order for a U.S. or Canadian medical school graduate to be eligible for entrance into an AMA approved hospital internship or residency, the applicant must have graduated from an accredited medical school. The only exception to this is the student who enters by the way of the so called "Fifth Pathway" which has been instituted in recent years.

#### THE PROCESS OF ACCREDITATION

The LCME membership includes six members appointed by the AAMC and six members appointed by the AMA, two public members selected by the LCME from nominations made by the parent organizations, and one federal liaison representative. These members represent a wide range of expertise within the medical profession, including educators and academicians, private practitioners of medicine, and hospital administrators as well as representatives of the public

sector and government. Over forty professionals plus the public members of the LCME, a student who is a member of the Executive Council of the AAMC, and a resident who is a member of the Council on Medical Education of the AMA, individually review and comment on the survey reports prepared for the LCME. These comments are recorded by the LCME Secretary and are presented as advice to the LCME when accreditation action is taken at its next scheduled meeting. The comments of each LCME voting member are also among those officially recorded. At each meeting there is discussion of the survey report and the recorded comments before final action is decided. Discussion is also elicited during the parent Council meetings at which time the actions of the LCME are subject to ratification.

In 1969 a formal system was established for rotating the Secretariat and Chairmanship of the LCME. This rotation system allows for a six-month overlap of the Secretariat and Chairmanship between the two parent organizations. This system permits one Secretary to arrange the schedule and carry out other logistics of the accrediting process for the total academic year. Full communication with the other organization's counterpart is consistently maintained on almost a day-to-day basis.

There are no honoraria or payments made to survey members by either the school, the accrediting agency or the parent organizations. An honorarium is offered to the team secretary if it is necessary to engage a non-staff member as secretary. A survey team generally consists of four members: a chairman, a secretary, and two members. The selection of the four team members is shared equally by the AMA and AAMC and there is a concerted effort to balance the teams from the standpoint of expertise and to avoid conflict of interest because of geographical location, previous institutional association and other similar considerations. It should be noted that no team member separately represents the AMA or the AAMC, but all represent the Liaison Committee on Medical Education. Finally, in a letter sent to the dean informing him of the survey team members, he is asked if the overall composition or any of the individual members present any significant conflict to the medical school, and if so, he is asked to so inform the LCME Secretary so that a change can be made.

In most cases, a full-time staff member of either the AMA or the AAMC serves as secretary of the survey team and takes responsibility for the completion of the survey report, although the determination of the opinions and judgments contained in the report and the recommendations is shared by the full team and there is ample opportunity for review of the report by the team before submission to the LCME. Further, there is opportunity for review of the report for the corrections of possible error of fact by the dean before the report is finalized. In addition, a verbal report of the team's findings is given at the conclusion of the visit, first to the dean, and then to the dean and president of the university. It is important to understand, however, that the survey team's recommendations are to the LCME and that the LCME has the prerogative of final action. Only rarely does the LCME make significant substantive changes in the survey reports, but on occasion it has required that they be rewritten and they have been returned to the team for this purpose.

The LCME does frequently shorten the period of time for which accreditation has been recommended or may impose a requirement for interim progress reports or staff visits. Also, in almost every instance, either the secretary, the chairman, or a team member, who made the site visit is present at the time the recommendations are discussed by the LCME. Appendix II summarizes LCME actions of recent years. Over the past five years, 47 schools have gained the full seven-year accreditation.

The Liaison Committee has also been concerned with the development of two-year schools of the basic medical sciences. A recent policy document, Special Criteria for Programs in the Basic Medical Sciences, categories the types of basic medical science programs that it will consider for accreditation as follows:

- "1. Existing two-year programs accredited or provisionally accredited,
2. New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium, and
3. New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case, the program will be accredited as a component of the M.D. degree-granting institution or institutions.

"It is the policy of the Liaison Committee to discourage the establishment of programs in the basic medical sciences for medical students that do not have a clearly defined pathway leading to the M.D. degree. Recognizing the need for mobilizing additional university resources for the benefit of medical education, the Committee may approve a basic medical science program through the M.D. degree-granting school with which it is affiliated. In this case the program will be surveyed initially upon request and subsequently as part of the regular review process of the affiliated medical school."

The LCME is recognized officially in the federal sector by the Office of Education, as the organization responsible for accreditation of undergraduate medical education programs. In the private sector, the LCME was recognized first by the National Commission for Accreditation which through a recent merger with FRACHE has become the Council on Postsecondary Accreditation (COPA). In requesting recognition by OE, the LCME must show in great detail how it functions, including its scope, how it is organized and administered and what its procedures are. Further, the LCME must demonstrate its responsibility, its reliability, and that it is autonomous. The criteria by which the Office of Education, DHEW, judges an accrediting agency on these four points are given in detail in Appendix III.

Annually, since 1901, the JAMA has published the "Education Number" which lists all the approved schools of medicine, schools of basic medical sciences, and developing medical schools. The AAMC published its first list of cooperating schools in 1896; this list included 55 of the approximate 150 schools in existence then. The list of accredited schools is now found also in the AAMC Directory which first appeared in 1952 and is published annually. Prior to that time, a list of member schools was published in the annual proceedings which was publicly available. Other sources publicly reporting the activities of the LCME are found in the AAMC Weekly Activities Report and the AAMC Annual Report. Actions of the LCME are made public, although the survey reports prepared on behalf of the LCME are considered to be privileged and can be made public only by the institution about which the report is made and to which it is officially transmitted. The reports are sent to the president of the institution with copies to the dean and to the Chairman of the Board of Trustees.

#### ACCREDITATION - HASSLE OR OPPORTUNITY?

Having described accreditation thus far as an element of the social structure concerned with maintaining a minimal standard of quality, let us consider the opportunities that the accreditation process provides for going beyond a minimal standard. Observation of the accreditation process and participation in some thirty-five to fifty reviews per annum over the past five years, leads to the observation that perhaps the developing schools profit most from the accreditation process. They are examined at frequent intervals, usually annually, and the LCME has become more and more explicit in its criticism of faculty competence and experience in the generation and transmission of knowledge, curriculum development, and criteria for admission of students. On the other hand, some of the established schools, graduating large numbers of students who invariably pursue a successful career in medicine, view accreditation as a periodic and necessary evil and treat it in a perfunctory way, except on occasion to express outrage that the visitors may not be as distinguished as the faculty which they are evaluating.

A few institutions have recognized the accreditation survey as an opportunity for a comprehensive program or departmental review of the entire institution and have employed it as an instrument for encouraging change and self-renewal. Academic institutions are notoriously slow to change and this is probably good in the long run. They set the standards in many areas important to the quality of life, and we look to this set of institutions as the critics of our social structure. However, change they will, and change they do, more often these days at the whim of external forces. It is not easy to keep ahead of the external forces for change. Nor, is it easy to initiate a major process of self-examination and evaluation within a complex organization. But, if medical schools are to have a hand in shaping their own future, they must know where their strengths lie, where their problems exist or will develop, and must have data which describes the present state of things. They must have thought through plans for how to deal with problems, set goals, assess limitations, and plan for the future. As Robert Kirkwood has said, "Accreditation in the finest sense is not an end but a means to an end."

A serious self-study by an institution, soundly planned and seriously executed, can become a powerful instrument for planning, evaluation and instituting necessary change throughout the organization. Institutions which expend their energies in concealing their problems until the accreditation team leaves are primarily wasting their own time and foregoing an opportunity for growth. The survey team does not come in the spirit of an examiner issuing a report card, but a group of colleagues or peers dedicated to serving the public good in helping the institution reach for the highest level of performance of which it is capable. The obligation of the survey team is to judge whether the institution has met a minimum standard. Its intention and approach are to be constructively helpful to the institution and to render the opinion of an objective outside group that has some basis of comparison with national standards. The institution which does not view the accreditation process as an opportunity which it can use creatively in its own interest cheats itself, hardly the survey team. William Kells has said, "Thanks to an increasing focus on institutional self-study and analysis of the outcomes of the educational process, accreditation at its best is quite effective. At its worst, it is a complete waste of time, a frantic jumping through hoops by institutions that have collected useless data."<sup>2</sup> Kells believes that institutional accreditation has two purposes: the first, to provide a means for members of the higher educational community to hold an institution accountable to its own stated objectives, and the second and most important is to improve educational processes and institutions. In the same article, he quotes Wendall Smith who said in response to a faculty member's initial disinterest, "Our accreditation may not be in question, but our future is."

If the institution has made its objectives clear and is able to demonstrate the extent to which it is meeting those objectives based on good evaluation procedures and output measures, it has no problem with accreditation. In this context, marked educational innovations can pass muster as easily as more traditional forms, since the object is the assessment of the clarity and merit of the objectives and the degree to which the institution has met its own stated objectives.

Beginning with the 1976-1977 academic session, the LCME will institute an organized institutional self-study system of accreditation of medical schools. This new approach to the periodic scrutiny of medical schools will call for increased faculty-student-administration involvement in identifying the strengths and weaknesses of its programs and the resources available in preparation for the visit by the survey team of the LCME. The staff of the LCME is prepared to work with each institution to be visited as the dean and faculty design their own analysis of institutional activities.

It is difficult, if not impossible, to evaluate the undergraduate medical education program without making a judgment about the nature of the graduate medical education program. As solutions are sought for improvements in the process for objective evaluation of graduate and continuing medical education programs, perhaps the self-study approach lends itself to a more comprehensive institutional view of accreditation of the continuum of medical education.

## CRITICISMS OF ACCREDITATION

The controversial Newman report, which was concerned primarily with innovation in higher education, highlighted what I believe to be the principal differences of opinion about accreditation among our own constituency. Newman said, "In the name of protecting the standards of education, regional and specialized accrediting organizations pressure new institutions to develop faculty, building and educational requirements on the pattern of established conventional colleges and universities. Moreover, these organizations -- dominated by the guilds of each discipline -- determine the eligibility of these new institutions for public support. We believe that 1) the composition of established accrediting organizations should be changed to include representatives of the public interest; and 2) federal and state government should reduce their reliance on these established organizations for determining eligibility for federal support."<sup>3</sup> A principal criticism of accreditation is, and we know it has been said of the LCME, that the standards are too rigid, the view is too conventional and encourages educational programs which are not responsive to the public need, nor to the need of the students. On the other hand, the LCME receives an equivalent, if not greater amount, of criticism from its parent associations and their Councils that the standards are not strict enough and are not applied vigorously enough. There is continuing expression that the quality of medical education is deteriorating and that the LCME needs some stiffening where its spine is located.

Recently, there appears to be a creeping conviction among some of our constituents that enrollment in American medical education has been expanded sufficiently to meet the needs of our nation for physicians and that the LCME should "stop allowing new medical schools to start." Irrespective of the merits of such opinions, the LCME cannot become involved in any broad question of restriction of the supply of health manpower if it is to maintain its well-practiced posture of impartial, fair consideration of the adequacy of the resources available for development of a new program in medical education presented by any university which applies for the preliminary stage of accreditation.

Until the last decade, accreditation was a voluntary process carried out exclusively in the private sector. Because of the GI Bill following World War II, the Office of Education Accreditation and Institutional Eligibility Staff (AIES, OE) was established to review and certify educational institutions as appropriate sites of training for veterans receiving educational benefits. Since then, the federal government has come to rely on the decisions of private accrediting agencies to establish the eligibility of institutions for an increasing number of federal programs for the support of postsecondary education. Accrediting agencies were not initially established to perform this function. Their basic function was to raise standards of the education offered in the institutions which they accredit. In the field of medical education, by virtue of fact that federal legislation since the mid 60's has mandated accreditation of an institution to establish its eligibility first for federal construction funds, and later operating funds, the Liaison Committee on Medical Education has, in a sense, become a quasi-governmental agency. With the last renewal of the federal Manpower Legislation, the LCME was required to provide advice to the Secretary, DHEW, as to whether enrollment increases for "bonus classes" would jeopardize the accreditation of the institution before the Secretary granted the additional funds.

In recent years, comfortable with its growing reliance on private accreditation, the federal government has moved to place accrediting agencies in the position of enforcing certain public policies. The Office of Education has attempted to force the accrediting body to enforce civil rights legislation in the area of discriminatory practices and has said that a criterion for recognition by OE must be the enforcement of ethical practices in hiring, admissions, etc. The position of the Liaison Committee is that no matter how laudable the social policy, it is inappropriate for the LCME to become an agency of enforcement of federal statutes and should concern itself only with the judgment of the quality of the education program and consider other matters only as they impinge upon and influence the quality of the educational program. It is only in this context, then, that the Liaison Committee believes that it can concern itself with the ethical practices of an organization which it is evaluating.

While some express concern that the net effect of accreditation in medicine has been a force for homogenizing institutions and particularly newer institutions and has precluded promising new ventures and departures from traditional practice, so far the LCME has avoided litigation. But as it continues to have to deny accreditation and thereby eligibility for funding, it becomes progressively more vulnerable. It is more than ever essential that its criteria and standards be clear, be applied with consistency, and that its decisions and actions be carefully thought through and documented. This is only fair practice in anyone's view, but it challenges the resources of the staff and the committee members alike. No one associated with the process can be too conscientious. Objectivity, integrity and fair play must be at a conscious level as the work of the committee is pursued.

Sensitive to the need for scrupulous observance of due process, the LCME developed an appeals process which was formally approved in June, 1973. The process provides, in the case of an adverse action, for the appointment of a formal subcommittee of the LCME to review the action. Representatives of the school have an opportunity to appear before the subcommittee to present material and information germane to the review. The subcommittee then returns the case to the LCME with the summation of the matters considered and the evidence presented. If the LCME sustains its adverse action, then the school may appeal the action prior to public disclosure. The appeal is then heard by an Appeals Board appointed for the purpose of hearing the appeal. Such Boards are appointed from an Appeals Panel composed of persons judged to be qualified by training experience and reputation to make a fair and reasoned recommendation regarding the merits of an accreditation decision, and who have no present connection with the LCME or its parent Councils. In each case requiring such action, a three-member Appeals Board is appointed from the panel as follows: one named by the Chairman, LCME, one named by the institution appealing the action, and the third member chosen by the first two named.

At the present time the U.S. Commissioner of Education's authority to recognize accrediting agencies derives from Congress' exercise of the spending power; it has delegated to the Commissioner the authority to determine the eligibility of institutions under federal aid programs for postsecondary

education. The "recognition" of accrediting agencies is not a direct exercise of regulatory power, but rather a function which exists due to and only in the context of federal funds expenditure, otherwise there is no need for the federal government recognition of accrediting agencies. Only those agencies in fields for which the federal government has spending power need to seek official federal recognition of their accrediting functions. Furthermore, an accrediting agency needs to be recognized only if it wishes the federal government to rely on its judgment in the process of expending federal funds, or if this has been mandated by federal statutes as is the case with certain funds relating to undergraduate medical education.

The recent report on "Respective Roles of the Federal Government and State Governments and Private Accrediting Agencies in the Governance of Postsecondary Education" by William A. Kaplin points out that any federal involvement in private accreditation or other aspects of postsecondary education deeper than that authorized by the spending power would have to be justified under one of Congress' regulatory powers. The only such power with major pertinence to his report is the "Commerce Power" which authorizes Congress (and administrators to whom Congress delegates power) to regulate activities which are in or which affect interstate commerce. A more detailed reference on this matter appears in Appendix IV. Kaplin goes on to point out, however, that the spending power remains for now and for the immediate future as the primary legal path for federal involvement in postsecondary education.

In a recent development, however, the Federal Trade Commission announced an investigation into whether the AMA may have "illegally restrained the supply of physicians and health-care services." According to reports, the thrust of the investigation by FTC will focus on three AMA activities: "its accreditation of medical schools and graduate programs; its definition of fields of practice for physicians and allied health personnel; and the limitations the AMA places on forms of health-care delivery inconsistent with the fee for service approach."<sup>5</sup>

#### OTHER PUBLIC POLICY ISSUES

The Equal Employment Opportunity Council (EEOC) an outgrowth of civil rights legislation of the mid-1960's is proposing to extend the applicability of its Uniform Guidelines on Employee Selection Procedures and through them its oversight from industry to the professions, including medicine. This is to be accomplished by extending the reach of the guidelines to licensing and certification boards and accrediting associations.

The guidelines apply to selection procedures which are used as a basis for any employment decision, which includes, but is not limited to any decision to hire, transfer, promote, demote, job or work assignments, membership (for example in labor organization) training, referral, retention, licensing and certification. It is not clear how accreditation directly affects any such decision, but the guidelines specifically state that they apply to accrediting associations.



The use of any selection procedure which is a standardized, formal, scored or qualified measure or combination of measures and which has an adverse impact on the members of any racial, ethnic or sex group with respect to any employment or membership opportunity will be considered to be discriminatory and inconsistent with the guidelines, unless the procedure is both validated and shown to be practically useful in accordance with the principles contained in the guidelines. An adverse impact on any racial, ethnic or sex group is demonstrated where the pass rate or selection rate is less than 80 percent of any other group. Each user of such a procedure is required to have available for inspection records or other information which will disclose the impact which its procedures have on opportunities of persons by identifiable racial, ethnic or sex groups in order to determine compliance.

It is clear that this is directly relevant to licensure, certification, and testing related to admission to medical school. It is not clear how this proposal relates to accreditation although the proposed EEOC Guidelines (which have the force of regulations once promulgated in the FEDERAL REGISTER) put the accreditation agencies on notice that they do. In addition to any presumed direct applicability of accreditation to employment decisions, it is assumed that the expectation of EEOC would be that accrediting agencies would withdraw accreditation from institutions which were presumed to employ discriminatory practices. Needless to say, the LCME is concerned with the concept proposed by EEOC as it affects the admissions process and that they may extend it to many other aspects of undergraduate medical education.

Another example of interest by a federal agency can be cited by the inquiry of the General Accounting Office last year. GAO undertook a general review of the accrediting process, including the organizational structure, operating procedures and actions of nationally recognized accrediting agencies and associations. The LCME responded to the inquiry, but we were not able to learn the purpose of the review nor the outcome.

Finally, recent state legislation of interest is the enactment or proposal of the so-called "Sunshine Laws" notably in Florida and California. While state statutes vary in detail, they would essentially require that a survey team visiting the medical school hold open public hearings on site; and, the LCME would be required to open all its accreditation records to public inspection, and open its deliberative proceedings to the public.

The concern is that these measures would inhibit frank, substantive discussion of findings and the necessary candid exchange of views in arriving at final judgments and in the transmission of constructive advice to the institutions. On the other hand, a criticism of accreditation from the public's standpoint is that while "all schools are accredited", there are not distinctions which are made public among the institutions on the matter of educational quality. Parents and students alike would like to know which are the "best medical schools"; but whose view of "best." The LCME and its parent associations assiduously avoid ranking of medical schools for any purpose.

In spite of continued efforts toward improvements, the accreditation process is an imperfect instrument. Nonetheless, it remains a principal instrument developed by the institutions and the profession as a means of monitoring and assessing institutional or program quality. The primary responsibility for assuring that educational programs are of acceptable quality rests with each institution. It is a responsibility borne primarily by its faculty exercising its collective academic judgment in the design and implementation of the curriculum, the assignment of competent educators, the selection of capable students and the evaluation of their performance. The institution is assisted in gauging its own performance through the availability of external assessment procedures and instruments. The accreditation process is a major instrument for such evaluation. It is also a major safeguard against encroachment by outside agents that desire to influence educational policy such as admissions standards or curriculum content. Recent examples of this kind of intrusion include two state legislatures which attempted to establish admissions criteria.

The support and assistance of the concerned institutions in improving and refining the process of accreditation is needed and actively sought. It is equally important to join in defending the integrity of voluntary accreditation from encroachment and dismantlement by federal authority and over-zealous critics of the system.

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<sup>2</sup>Kells, Herbert R., "Institutional Accreditation: New Forms of Self-Study", Educational Record, Vol. 53, No. 2 (Spring Issue), 1972, pp. 143-148.

<sup>3</sup>Report on Higher Education, March 1, 1971, Frank Newman, Stanford University, Chairman of Task Force, p.66.

<sup>4</sup>Kaplin, William A., "Prespective Roles of Federal Government, State Governments, and Private Accrediting Agencies in the Governance of Post-secondary Education", The Council on Postsecondary Accreditation, 1975, pp. 10-12.

<sup>5</sup>"AMA Role in Supply of Doctors, Services Set for FTC Study", Wall Street Journal, April 14, 1976.

HISTORY OF AAMC AND AAMC INVOLVEMENT IN ACCREDITATION  
AND THE FOUNDATION AND ACTIVITIES OF THE  
LIAISON COMMITTEE ON MEDICAL EDUCATION

Precursor - Establishing minimum standards

1876 - organization of AAMC - 22 medical colleges  
Resolutions and proposals

Opposed to issuing diplomas without the  
graduate's name

Medical course to consist of three courses  
of lectures, at least 20 weeks each

1877 - 15 medical colleges

All colleges extend annual term to six months,  
medical course to be three years in length

1882 - 11 medical colleges

Break up of Association because too many  
schools could not conform to the three  
year rule

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1890 - 66 medical colleges - meeting called to discuss:

1. Three year course of six months each
2. Graded curriculum
3. Written and oral examinations for graduation
4. Laboratory instruction: chemistry, histology, pathology
5. Examination in English for admission

1905 - Requirements for AAMC membership:

1. High school diploma or equivalent for admission
2. Examinations before graduation
3. Adherence to a standard curriculum, four years in length, 4,000 hours

1905 AAMC standards adopted by National Confederation  
of State Medical and Licensing Boards.

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1903 - AAMC began inspections of member schools

1904 - AMA Council on Medical Education and Hospitals established.

1907 - First AMA classification of ABC schools

1908 - AAMC published schedule of minimal equipment every "high grade" medical school should have Adopted by Confederation of State Boards

1910 - Flexner Survey commissioned by AMA: found that 35 of 50 member schools not meeting AAMC minimal standards

"Essentials of an Acceptable Medical School" approved by AMA House of Delegates

1913 - First joint action by AAMC and AMA  
One year of college, required, admission to medical year

"Essentials" revised

1914 - First school dropped by AAMC for not conforming to minimal standards - five others warned

1916 - AAMC-AMA Two years of college for medical school admission

1918 - AAMC-AMA list of accredited medical colleges accepted Federation of State Medical Boards

1919 -- AAMC-AMA first joint inspection of medical schools

1925 - AAMC-Commission on Medical Education

1927 - "Essentials" revised

1932 - Publication report Commission on Medical Education: Willard Rappleye

1933 - "Essentials" revised

1934 - "Essentials" revised.

1936 - "Essentials" revised.

1938 - "Essentials" revised.

- 1942 - AAMC-AMA - Liaison Committee on Medical Education established.
- 1945 - "Essentials" revised.
- 1951 - "Essentials" revised.
- 1952 - AAMC-published objectives of undergraduate medical education - incorporated in AAMC-AMA statement of "Essentials of Acceptable Medical Schools both two and four year programs
- 1957 - Revision of "Functions and Structures of a Modern Medical School by AMA House of Delegates and AAMC Assembly.
- 1958 - Adoption of "Functions and Structures of a School of Basic Medical Sciences" by the AMA House of Delegates and the AAMC Assembly.
- Development of joint AMA-AAMC questionnaires under the sponsorship of the LCME.
- 1963 - Adoption of the final report of the LCME Committee on Accreditation Procedures
- Federal Statute PL88 - 129  
Requires accreditation by agency recognized by Commissioner of Education as a condition of eligibility for Federal grants under new programs.
- 1969 - Enlargement of the LCME to include a Federal and public representative
- Participation of New York State Representatives on site visits to schools in New York State.
- 1970 - Adoption of Proposal for the Expansion of the Membership and Function of the LCME by the LCME, AMA-CME, and AAMC Executive Council.
- 1972 - Adoption of "Functions and Structure of a Medical School" by the AAMC Assembly.
- 1973 - Adoption of "Functions and Structure of a Medical School" by the AMA House of Delegates.
- Adoption of "Special Criteria for Programs in the Basic Medical Sciences" by the AAMC Assembly and the AMA House of Delegates.

SUMMARY OF LCME DECISIONS ON ACCREDITATION IN USA  
1957 - 1974

	Total Actions	No. Actions other than LRA or Prov. Approval	Maximum Term of Full Approval		Time Limited Full Approval Years					Probation (Confidential prior to 1968)	Provisional Approval	LRA
			No.	%	5	4	3	2	1			
1957 - 58	11	9	3	33%			3	2		1	2	
1958 - 59	11	11	8	73%		1			1	1		
1959 - 60	13	12	9	75%	1		2				1	
1960 - 61	14	13	9	69%			1	2		1	1	
1961 - 62	17	15	10	67%			1			4	2	
1962 - 63	17	14	9	64%	1		1		1	2	2	1
1963 - 64	13	12	9	75%			3				1	
1964 - 65	20	11	5	45%	1	1	1	1		2	2	7
1965 - 66	12	12	5	41%	2	2				3		
1966 - 67	16	13	8	61%		1	1			3	2	1
1967 - 68	14	11	11	100%						confidential	3	
1968 - 69	26	21	15	71%			4	1		open 1	3	2
1969 - 70	30	24	15	62%	1	2	1	4	1		1	5
1970 - 71	36	24	16	66%	1		2	5			10	2
1971 - 72	21	15	5	33%	2		3	4		1	5	1
1972 - 73	31	20	10	50%	2	1	4	2		1	11	
1973 - 74	25	19	5	26%		5	1	6	2		4	2
1974 - 75	32	29	11	38%	2	5	2	7	1	1	2	1

11/20/75

JRS/ke

Excerpt from: Nationally Recognized Accrediting Agencies and Associations

Criteria and Procedures for Listing by the U.S. Commissioner of Education and Current List, August 1974, by The Accreditation and Institutional Eligibility Staff, U.S. Department of Health, Education, and Welfare, Office of Education, Bureau of Post-secondary Education, pages 7-9.

§ 149.6 Criteria.

In requesting designation by the U.S. Commissioner of Education as a nationally recognized accrediting agency or association, an accrediting agency or association must show:

- (a) Functional aspects. Its functional aspects will be demonstrated by:
  - (1) Its scope of operations:
    - (i) The agency or association is national or regional in its scope of operations.
    - (ii) The agency or association clearly defines in its charter, by-laws or accrediting standards the scope of its activities, including the geographical area and the types and levels of institutions or programs covered.
  - (2) Its organization:
    - (i) The agency or association has the administrative personnel and procedures to carry out its operations in a timely and effective manner.
    - (ii) The agency or association defines its fiscal needs, manages its expenditures, and has adequate financial resources to carry out its operations, as shown by an externally audited financial statement.
    - (iii) The agency's or association's fees, if any, for the accreditation process do not exceed the reasonable cost of sustaining and improving the process.
    - (iv) The agency or association uses competent and knowledgeable persons, qualified by experience and training, and selects such persons in accordance with nondiscriminatory practices: (A) to participate on visiting evaluation teams; (B) to engage in consultative services for the evaluation and accreditation process; and (C) to serve on policy and decision-making bodies.
    - (v) The agency or association includes on each visiting evaluation team at least one person who is not a member of its policy or decision-making body or its administrative staff.
  - (3) Its procedures:
    - (i) The agency or association maintains clear definitions of each level of accreditation status and has clearly written procedures for granting, denying, reaffirming, revoking, and reinstating such accredited statuses.
    - (ii) The agency or association, if it has developed a preaccreditation status, provides for the application of criteria and procedures that are related in an appropriate manner to those employed for accreditation.
    - (iii) The agency or association requires, as an integral part of its accrediting process, institutional or program self-analysis and an on-site review by a visiting team.



(A) The self-analysis shall be a qualitative assessment of the strengths and limitations of the institution or program, including the achievement of institutional or program objectives, and should involve a representative portion of the institution's administrative staff, teaching faculty, students, governing body, and other appropriate constituencies.

(B) The agency or association provides written and consultative guidance to the institution or program and to the visiting team.

(b) Responsibility. Its responsibility will be demonstrated by the way in which —

(1) Its accreditation in the field in which it operates serves clearly identified needs, as follows:

(i) The agency's or association's accreditation program takes into account the rights, responsibilities, and interests of students, the general public, the academic, professional, or occupational fields involved, and institutions.

(ii) The agency's or association's purposes and objectives are clearly defined in its charter, by-laws, or accrediting standards.

(2) It is responsive to the public interest, in that:

(i) The agency or association includes representatives of the public in its policy and decision-making bodies, or in an advisory or consultative capacity that assures attention by the policy and decision-making bodies.

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

(A) The standards by which institutions or programs are evaluated;

(B) The procedures utilized in arriving at decisions regarding the accreditation status of an institution or program;

(C) The current accreditation status of institutions or programs and the date of the next currently scheduled review or reconsideration of accreditation;

(D) The names and affiliations of members of its policy and decision-making bodies, and the name(s) of its principal administrative personnel;

(E) A description of the ownership, control and type of legal organization of the agency or association.

(iii) The agency or association provides advance notice of proposed or revised standards to all persons, institutions, and organizations significantly affected by its accrediting process, and provides such persons, institutions and organizations adequate opportunity to comment on such standards prior to their adoption.

(iv) The agency or association has written procedures for the review of complaints pertaining to institutional or program quality, as these relate to the agency's standards, and demonstrates that such procedures are adequate to provide timely treatment of such complaints in a manner that is fair and equitable to the complainant and to the institution or program.

(3) It assures due process in its accrediting procedures, as demonstrated in part by:

(i) Affording initial evaluation of the institutions or programs only when the chief executive officer of the institution applies for accreditation of the institution or any of its programs;

(ii) Providing for adequate discussion during an on-site visit between the visiting team and the faculty, administrative staff, students, and other appropriate persons;

(iii) Furnishing, as a result of an evaluation visit, a written report to the institution or program commenting on areas of strengths, areas needing improvement and, when appropriate, suggesting means of improvement and including specific areas, if any, where the institution or program may not be in compliance with the agency's standards;

(iv) Providing the chief executive officer of the institution or program with an opportunity to comment upon the written report and to file supplemental materials pertinent to the facts and conclusions in the written report of the visiting team before the accrediting agency or association takes action on the report;

(v) Evaluating, when appropriate, the report of the visiting team, preferably the chairman;

(vi) Providing for the withdrawal of accreditation only for cause, after review, or when the institution or program does not permit reevaluation, after due notice;

(vii) Providing the chief executive officer of the institution with a specific statement of reasons for any adverse accrediting action, and notice of the right to appeal such action;

(viii) Establishing and implementing published rules of procedure regarding appeals which will provide for:

(A) No change in the accreditation status of the institution or program pending disposition of an appeal;

(B) Right to a hearing before the appeal body;

(C) Supplying the chief executive officer of the institution with a written decision of the appeal body, including a statement of specifics.

(4) It has demonstrated capability and willingness to foster ethical practices among the institutions or programs which it accredits, including equitable student tuition refunds and nondiscriminatory practices in admissions and employment.

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

(6) It secures sufficient qualitative information regarding the institution or program which shows an on-going program evaluation of outputs consistent with the educational goals of the institution or program.

(7) It encourages experimental and innovative programs to the extent that these are conceived and implemented in a manner which ensures the quality and integrity of the institution or program.

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

(9) It reevaluates at reasonable intervals institutions or programs which it has accredited.

(10) It requires that any reference to its accreditation of accredited institutions and programs clearly specifies the areas and levels for which accreditation has been received.

(c) Reliability. Its reliability is demonstrated by --

(1) Acceptance throughout the United States of its policies, evaluation methods, and decisions by educators, educational institutions, licensing bodies, practitioners, and employers;

(2) Regular review of its standards, policies and procedures, in order that the evaluative process shall support constructive analysis, emphasize factors of critical importance, and reflect the educational and training needs of the student;

(3) Not less than two years' experience as an accrediting agency or association;

(4) Reflection in the composition of its policy and decisionmaking bodies of the community of interests directly affected by the scope of its accreditation.

(d) Autonomous. Its autonomy is demonstrated by evidence that --

(1) It performs no function that would be inconsistent with the formation of an independent judgment of the quality of an educational program or institution;

(2) It provides in its operating procedures against conflict of interest in the rendering of its judgments and decisions.

(20 U.S.C. 1141(a))

Excerpt from: "Respective Roles of Federal Government, State Governments, and Private Accrediting Agencies in The Governance of Postsecondary Education", William A. Kaplin, The Council on Postsecondary Accreditation, 1975, p. 11.

Courts have held that this power justifies establishment of federal wage and hour standards for employment in public and private higher educational institutions engaged in commerce (Maryland v. Wirtz, 392 U.S. 183 (1968)) and federal regulation of labor-management relations in private institutions of higher education (e.g., Cornell University, 183 NLRB No. 41, 74 LRRM 1269 (1970)). This power is also the legal basis for Federal Trade Commission jurisdiction over proprietary schools which "commit unfair or deceptive acts or practices in Commerce" (15 U.S.C. §345(a)) and would permit extension of similar jurisdiction to non-profit postsecondary institutions. Any future application of antitrust laws to postsecondary educational institutions or accrediting associations would also be based on the commerce power.<sup>11/</sup>

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11. See generally, regarding postsecondary education and the antitrust laws, Wang, "The Unbundling of Higher Education," 1975 Duke L.J. 53. And for a recent Supreme Court decision rejecting the existence of a "learned professions exemption" under which accrediting agencies have sometimes claimed immunity from antitrust laws, see Goldfarb v. Virginia State Bar, 43 U.S. Law Week 4723 (1975).

# LIAISON COMMITTEE ON MEDICAL EDUCATION

## Attachment A

Council on Medical Education  
American Medical Association  
535 North Dearborn Street  
Chicago, Illinois 60610

Executive Council  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D.C. 20036

### PROCEDURES LEADING TO PROVISIONAL ACCREDITATION OF NEW MEDICAL SCHOOLS

#### 1. Staff Discussion Stage --

Early  
Reference  
Packet

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

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

1. LCME description - NCA document -
2. "Information to be Submitted by Developing  
Medical Schools"
3. "Functions and Structure," appendices -
4. This document
5. Policy statement: "Interrelationship of Basic  
and Clinical Sciences!"

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

Detailed  
References

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

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

-- Staff will record a brief summary of the dialogue occur-  
ring during primary visits and enter this information period-  
ically into a quarterly agenda of the LCME.

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

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

Staff Visit

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

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Liaison Committee on Medical Education  
Page Two

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

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

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

A. Before appointment of the Dean --

Member-Staff  
Consultation  
Visit

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

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

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

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

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B. After appointment of the Dean --

-- Following the appointment of the Dean, experience has shown that the school will need 18 to 30 months for accomplishment of early planning of facilities, recruitment of a nucleus of faculty, acquisition of necessary financial resources, mobilization of community resources, etc. The Dean should avail himself of consultation available from Senior Staff, particularly those who made the consultation on site. It would be expected that the Dean would make periodic visits to the offices of the parent councils to obtain this service and to report progress.

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

-- On the basis of the information available about a proposed new project in medical education, the LCME may require that this consultation visit (stage 2) be held first or be waived in favor of direct progression to Stage 4, Pre-Accreditation Survey.

3. Reasonable Assurance for Provisional Accreditation -- a fee will be charged.

Governmental or other agencies may require "Reasonable Assurance" as a condition for considering an application for financial assistance from, or granting an award to a proposed medical school.

Reasonable  
Assurance

Upon request the Liaison Committee on Medical Education may authorize a statement or Letter of Reasonable Assurance. Before doing so the LCME will determine that there is an acceptable plan for the development of the proposed school which, if implemented as projected, may reasonably be expected to conform to the requirements for accreditation as described in the statement "Functions and Structure of a Medical School," and that there is a reasonable probability that the plan will be implemented.

"Reasonable Assurance" does not commit the Liaison Committee to the granting of provisional accreditation.

4. Pre-Accreditation Survey -- a fee will be charged.

Experience has indicated that this step in the development of a new medical school is the most significant of all. Provisional accreditation will not be granted until there is convincing evidence that the proposed medical school will meet the requirements for accreditation at the time proposed for admission of the stated number of initial students.

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

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

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

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

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

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

Formal Pre-  
Accreditation  
Survey

Liaison Committee on Medical Education  
Page Five

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

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



QUALITY RATING SHEET

School \_\_\_\_\_

Date of Survey \_\_\_\_\_

(Check one; write Comments on attached pages)

Adequate   Marginal   Inadequate

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

Quality Rating Sheet  
Page 2

School \_\_\_\_\_

Date of Survey \_\_\_\_\_

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

Summary Evaluation:

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

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



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John R. Proffitt  
19, 1972

Attachment B

Question 6: Is the LCME seeking renewal of recognition of its accreditation category of reasonable assurance, or has this category been replaced by provisional approval?

Response: Reasonable assurance of accreditation is not the equivalent to the LCME's provisional accreditation.

The issuance of letters of reasonable assurance of accreditation is included in the LCME procedures in accommodation to Federal statutory requirements; the receipt of such information by the Secretary of HEW has been a statutory prerequisite for eligibility to receive Federal grants under the Health Professions Educational Assistance Act of 1963 (P.L. 88-129), Health Professions Educational Assistance Amendments of 1965 (P.L. 89-290), the 1968 Health Manpower Act (P.L. 90-490) and the 1971 Comprehensive Health Manpower Training Act (P.L. 92-157) (Appendix 5). In 1968 the staffs of the Bureau of Health Professions Education and Manpower Training (now the Bureau of Health Manpower Education), the AMA and the AAMC developed guidelines (Attachment 4) for the issuance of such letters for expanding and developing schools. The 1968 law required under section 721:

"(b) (1) To be eligible to apply for a grant to assist in the construction of any facility under this part (Part B - Grants for Construction of Teaching Facilities for Medical, Dental, and other Health Personnel), an applicant must be (A) a public or other non-profit school of medicine . . . and (B) accredited by a recognized body or bodies approved for such purposes by the Commissioner of Education, except that a new school which (by reason of no, or an insufficient, period of operation) is not, at the time of application for a grant . . . eligible for accreditation . . . shall be deemed accredited for purposes of this part if . . . there is reasonable assurance that the school will meet the accreditation standards . . . (i) prior to the beginning of the academic year following the normal graduation date of the first entering class . . . or (ii) if later, upon completion of the project . . ."

Similarly Sec. 773 provides:

"(b) To be eligible for a grant under this part, (Part E - Grants to Improve the Quality of Schools of Medicine, Dentistry, etc.) the applicant must (1) be a public or other non-profit school of medicine . . . (2) be accredited by a recognized body . . . approved for such purpose by the Commissioner of Education, except that the requirement of this clause (2) shall be deemed to be satisfied if, (A) in the case of a school which by reason of no, or an insufficient, period of operation is not, at the time . . . eligible for such accreditation . . . there is reasonable assurance that the school will meet accreditation standards . . . prior to the beginning of the

4  
John R. Proffitt  
19, 1972

academic year following the normal graduate date of students who are in the first year of instruction . . . (at the time the grant is approved) or (B) in the case of any other school, . . . there is reasonable ground to expect that, with the aid of a grant or grants under this part . . . such school will meet such accreditation standards within a reasonable time."

The 1971 law requires under Section 775:

"(b) to be eligible for a grant under section 770 [Capitation], 771 [Start up], 772 [Special Projects], or 773 [Financial Distress], the applicant must (1) be a public or other non-profit school of medicine. . . . and (2) be accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, expect that the requirement of this clause shall be deemed to be satisfied if (A) in the case of a school which by reason of no, or an insufficient, period of operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Commissioner finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduate date of students who are in their first year of instruction at such school during the fiscal year in which the Secretary makes a final determination as to approval of the application, or (B) in the case of any other school, the Commissioner finds after such consultation and after consultation with the Secretary that there is reasonable ground to expect that, with the aid of the grant (or grants) under those sections, having regard for the purposes of the grant for which application is made, such school will meet such accreditation standards within a reasonable time."

These provisions may be found in Title III of the Public Health Service Act.

Therefore, the Liaison Committee provides the Secretary, through his representatives, the appropriate assurances that developing medical schools, i.e., those schools which have not matriculated students, have been surveyed and may reasonably anticipate accreditation. Provisional accreditation is granted immediately prior to enrollment of the charter class and following the favorable recommendation of a full-scale site visit team survey.

Question 7: What is the status of the review of the standards for schools in the basic medical sciences which the petition implies is underway?

Response: At the January 12, 1972 meeting of the LCME, the Chairman was instructed to appoint a subcommittee to update and rewrite the 1953 document, "Functions and Structure of a Modern School of Basic

-50-  
Attachment C

SUMMARY OF LCME DECISIONS ON ACCREDITATION IN USA  
1957 - 1974

	Total Actions	No. Actions other than LRA or Prov. Approval	Maximum Term of Full Approval		Time Limited Full Approval Years					Probation (Confidential prior to 1968)	Provisional Approval	LRA
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1958 - 59	11	11	8	73%		1				1		
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1960 - 61	14	13	9	69%			1	2		1	1	
1961 - 62	17	15	10	67%			1			4	2	
1962 - 63	17	14	9	64%	1		1		1	2	2	1
1963 - 64	13	12	9	75%				3			1	
1964 - 65	20	11	5	45%	1	1	1	1		2	2	7
1965 - 66	12	12	5	41%	2	2				3		
1966 - 67	16	13	8	61%		1	1			3	2	1
1967 - 68	14	11	11	100%						confidential	3	
1968 - 69	26	21	15	71%				4	1	open 1	3	2
1969 - 70	30	24	15	62%	1	2	1	4	1		1	5
1970 - 71	36	24	16	66%	1		2	5			10	2
1971 - 72	21	15	5	33%	2		3	4		1	5	1
1972 - 73	31	20	10	50%	2	1	4	2		1	11	
1973 - 74	25	19	5	26%		5	1	6	2		4	2
1974 - 75	32	29	11	38%	2	5	2	7	1	1	2	1

11/20/75

JRS/ke

# 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.

THE FOLLOWING SUPPLEMENTARY STATEMENTS  
WERE ADOPTED BY THE LIAISON COMMITTEE  
ON MEDICAL EDUCATION AT ITS OCTOBER  
16-17, 1974 MEETING.

#### Due Process

A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and "due process" must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him/her of valuable rights.

#### Confidentiality of Medical Student Health Records

The Liaison Committee on Medical Education expects medical schools to follow customary standards in regard to the confidentiality of student health records, including the standards and practices recommended by the American College Health Association.

#### Confidentiality of Medical Student Records

In the spirit of fairness and "due process," there should be no secret record-keeping systems and the student should have appropriate access to his/her records, with the right to challenge the accuracy of the information contained therein. Moreover, with the exception of administrative officers, committee and faculty members of the medical school, the student's records are to be made available only upon written request by the student.

Attachment E

LIAISON COMMITTEE ON

CONTINUING MEDICAL EDUCATION (LCCME)

REPRESENTING: *American Board of  
Medical Specialties*

SAUL J. FARBER, M.D.  
New York University Medical Center

GEORGE F. REED, M.D.  
State University of New York  
Upstate Medical Center

JERALD R. SCHENKEN, M.D.  
8303 Dodge Street  
Omaha, Nebraska

REPRESENTING: *American Hospital  
Association*

MR. DONALD W. CORDES  
Executive Vice President  
Iowa Methodist Hospital, Des Moines

MR. HARRY C.F. GIFFORD  
President  
Medical Center of Western Massachusetts  
Springfield

MR. ROBERT F. SCATES  
Administrator  
Baptist Memorial Hospital, Memphis

REPRESENTING: *American Medical  
Association*

JOHN H. KILLOUGH, M.D.  
Associate Dean  
Jefferson Medical College

DONALD W. PETIT, M.D.  
University of Southern California  
School of Medicine

CHARLES N. VERHEYDEN, M.D.  
Mayo Clinic  
Rochester, Minnesota

J. JEROME WILDGEN, M.D.  
Sunset Blvd. & Nevada Street  
Kalispell, Montana

REPRESENTING: *Association for Hospital  
Medical Education*

GAIL I. BANK, Ph.D.  
Executive Director, Postgraduate Medicine  
University of Missouri-Columbia  
School of Medicine

REPRESENTING: *Association of American  
Medical Colleges*

RICHARD M. BERGLAND, M.D.  
Division of Neurosurgery  
Pennsylvania State University  
College of Medicine

WILLIAM D. MAYER, M.D.  
Director, Health Services Research  
Center Program  
University of Missouri-Columbia

JACOB R. SUKER, M.D.  
Associate Dean  
Northwestern University Medical School

REPRESENTING: *Council of Medical Specialty  
Societies*

JOHN CONNOLLY, M.D.  
Department of Surgery  
University of California, Irvine  
California College of Medicine

JAMES L. GROBE, M.D.  
136 E. Desert Park Lane  
Phoenix, Arizona

CHARLES V. HECK, M.D.  
Executive Director  
American Academy of Orthopaedic Surgeons

REPRESENTING: *Federation of State Medical  
Boards*

HOWARD L. HORNS, M.D.  
2001 Blaisdell Avenue  
Minneapolis, Minnesota

REPRESENTING: *Federal Representative*

FREDERICK V. FEATHERSTONE, M.D.  
Assistant Director for Planning  
Division of Medicine  
National Institutes of Health

Attachment F

AAMC GROUP ON MEDICAL EDUCATION

STEERING COMMITTEE, 1975-76

MERREL D. FLAIR, Ph.D. (Chairman)  
Director of Medical Studies  
University of North Carolina  
School of Medicine  
AREA: *Graduate Medical Education*

DAVID S. SCOTCH M.D. (Chairman,  
Associate Dean Northeast Region)\*  
New York University  
School of Medicine  
AREA: *Research in Medical Education*  
*Biomedical Communications*  
*Undergraduate Medical Education*  
*Graduate Medical Education*

ROBERT A. BARBEE, M.D. (Chairman-Elect)  
Associate Professor of Medicine  
University of Arizona  
College of Medicine  
AREA: *Graduate Medical Education*

GARY E. STRIKER, M.D. (Chairman,  
Assistant Dean Western Region)  
for Curriculum  
University of Washington  
School of Medicine (Seattle)  
AREA: *Undergraduate Medical Education*

CHRISTINE McGUIRE (Past Chairman)  
Evaluation and Research Section  
Center for Educational Development  
University of Illinois  
College of Medicine (Chicago)  
AREA: *Research in Medical Education*

ROBERT J. McCOLLISTER, M.D. (Chairman,  
Assistant Dean and Central  
Curriculum Coordinator Region)\*  
University of Minnesota  
Medical School (Minneapolis)  
AREA: *Research in Medical Education*  
*Undergraduate Medical Education*

CLYDE E. TUCKER, M.D. (Secretary)  
Director, Educational Services  
University of Colorado  
School of Medicine  
AREA: *Biomedical Communications*

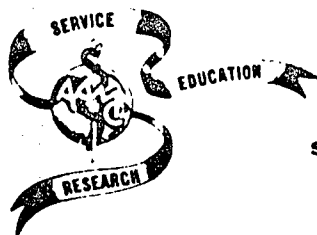
JAMES R. SCHOLTEN, M.D. (Chairman,  
Assistant Dean Southern Region)  
Eastern Virginia Medical School  
AREA: *Undergraduate Medical Education*

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\*At the May regional meetings, the following changes will be made:

ROBERT F. SCHUCK, Ed.D. (Replacing Dr. Scotch as Chairman, Northeast Region)  
Director,  
Division of Research in Medical Education  
University of Pittsburgh  
School of Medicine  
AREA: *Research in Medical Education*

GUNTER GRUPP, M.D. (Replacing Dr. McCollister as Chairman, Central Region)  
Chairman,  
Department of Biomedical Communications  
University of Cincinnati  
College of Medicine  
AREA: *Biomedical Communications*



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

June 8, 1976

John B. Wolff, Ph.D.  
Treasurer  
Biophysical Society  
Westwood Building, Room 4A07  
5333 Westbard Avenue  
Bethesda, Maryland 20016

Dear Dr. Wolff:

I regret that the Biophysical Society has decided to withdraw from the Council of Academic Societies. It appears to me to be a particularly unpropitious time for a scientific organization with the stature of the Biophysical Society to decide to withdraw from the organization which has placed greatest emphasis on maintaining the overall viability and integrity of research and education in the biomedical sciences.

In your letter you state that the Biophysical Society feels that with its relatively small membership it can have little impact on the work of the CAS or the AAMC. Perhaps there is a misunderstanding regarding how member societies can, and must, relate to an organization such as the Council of Academic Societies if the scientific community is to be regarded as an entity interested in promoting its own needs in order to act in the public interest. Weekly, you, the other officers of the Biophysical Society, and the Society's representatives to the CAS receive John Cooper's Weekly Activities Report which is intended to call to your attention the critical issues which are facing the academic and scientific community. Quarterly, in an effort to better inform the membership-at-large of each member society, the CAS Brief is now being circulated.

Further, the CAS has sponsored legislative workshops in the past and will do so again this year. The purpose of these seminars is to educate representatives of member societies with regard to the legislative process and to suggest ways in which member societies can become more effective in those political areas which

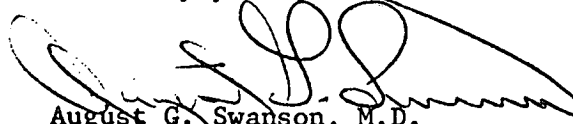
John B. Wolff, Ph.D.  
June 8, 1976 - Page Two

affect their professional lives. At a time when biomedical science has fallen from favor from an increasingly anti-science Congress, it is hard to understand why any group would withdraw from an effort to counteract the Congressional mood.

Only if the officers and representatives of the societies seek personal, active interaction on these issues with the officers and staff of the CAS can we be effective. Several of the member societies have been extremely effective because of the personal commitment individuals have given to the broad goals of the biomedical science community.

If each disciplinary society believes that its interests are only narrowly those of its members' discipline, then the integrity of the entire biomedical science exercise will be split asunder. We here at the Association stand ready to work interactively with all of our member societies, but there must be a responsive initiation of effort from the field. It is my hope that your Executive Board will reconsider its decision to withdraw from the CAS at this time.

Sincerely yours,



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

AGS/ms

# BIOPHYSICAL SOCIETY

OFFICE OF THE TREASURER

Westwood Building, Room 4 A 07  
5333 Westbard Avenue  
Bethesda, Maryland 20016

May 7, 1976

Association of American Medical Colleges  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear Sir:

We have received your invoice No. 83087 dated 5-3-76 for \$2,000 dues for renewed membership of the Biophysical Society in the Council of Academic Societies for the year July 1, 1976 through June 30, 1977.

The Council of the Biophysical Society has been debating the advantages and drawbacks of continued membership in the CAS for about a year now. The Council has acknowledged and admired the effective efforts of the AAMC on behalf of increasing federal support of fundamental research in the biomedical sciences, and we hope that these endeavors will continue to be successful. However, the Biophysical Society feels that with its relatively small membership it can have little impact on the work of the CAS or the AAMC. The Council also considers the assessment of \$2,000 annual dues to be disproportionately high for the benefits derived by our members, and our petition to have the dues reduced failed to receive a favorable response from the AAMC.

The Executive Board of the Biophysical Society, acting on behalf of the Council, at its meeting on April 17, 1976 therefore voted unanimously to discontinue our affiliation with the CAS of the AAMC as of July 1, 1976. We regret having to take this action, and we wish the AAMC continued success in its very worthwhile work.

Sincerely,

John B. Wolff, Ph.D.  
Treasurer

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MILTON T. EDGERTON, M.D., Chairman  
GAYLORD S. WILLIAMS, M.D.  
RICHARD F. EDLICE, M.D.  
WILLIAM FURRELL, M.D.  
JAMES W. FOX, M.D.  
GERALD T. GOLDEN, M.D.  
JOHN M. HEBERT, M.D.  
JEFFREY L. MARSH, M.D.

NORMAN J. KNORR, M.D. (Psychiatry)  
FRANK C. MCCUE, M.D. (Orthopedics)  
CHARLES R. BOECHARDT, D.D.S. (Oral Surgery)  
T. THOMAS KASLER, D.M.D. (Oral Surgery)  
THOMAS E. WILLIAMS, D.D.S. (Oral Surgery)  
CHARLES M. MANNING, D.D.S. (Orthodontics)  
JOHN F. WOLFE, JR., D.D.S. (Orthodontics)

UNIVERSITY OF VIRGINIA MEDICAL CENTER

DEPARTMENT OF PLASTIC SURGERY

CHARLOTTESVILLE, VIRGINIA 22901



May 19, 1976

Dr. August G. Swanson  
Director, Association of  
American Medical Colleges  
Suite 200  
1 DuPont Circle, N.W.  
Washington, D.C. 20036

Dear Dr. Swanson:

I received your recent two page news letter on public policy issues in regard to CAS and AAMC.

This is a helpful practice, and I hope it will be continued. I will certainly forward it in the hopes that all the members of the American Association of Plastic Surgeons may be informed.

You asked for response concerning Health Manpower Bill S3239, and other activities in progress.

I would like personally to echo a concern recently expressed well by the American College of Surgeons. Namely that we should "carefully rethink the exact definition and meaning of primary care." I believe the medical profession has been very remiss in not conducting a strong educational campaign to apprise laymen and politicians of the multiple ways in which American citizens have entered the health care system for many decades in this country. If a patient needing medical care can manage first to seek that care from a specialist most acquainted with that condition, we not only have a maximum economic efficiency, but also the ideal situation from the standpoint of rendering treatment to that disease. As an example in point, in our own Medical Center, patients coming into the Plastic Surgery Clinic (by most standards this is considered a definite "speciality") indicate that they are coming directly without previous physician contact in over 60% of the patients. Similar figures could be undoubtedly shown to exist with many other so called medical specialities.

Dr. August G. Swanson  
May 19, 1976  
Page Two

The American citizen has become relatively sophisticated in seeking the proper specialist within the past decade. We should do nothing to discourage that effective method of getting health care.

Many of us fear that the tremendous emphasis on primary care specialities may result in effort to filter all patients through such types of physicians, with the only result being greater expense, loss of time, and delayed medical care. The country cannot afford such inefficiencies.

It is true that a small percentage of patients need diagnostic help before they know the proper specialist to seek. For this group of patients (well under 5% of all patients) a diagnostic primary triage type of physician should be available. In most instances this could be a pediatrician or someone trained in internal medicine. Surely CAS could be instrumental in making clear that medical specialities take care of an enormous number of patients at the present time, as true "primary care"?

Please let me know if you think there is any possibility that CAS can be effective in this direction.

Sincerely yours,

Milton T. Edgerton, M.D.

MTE/lc

cc: Dr. Robert McCormick  
Dr. Carl Chism

THE UNIVERSITY OF ROCHESTER  
SCHOOL OF MEDICINE AND DENTISTRY  
AND  
STRONG MEMORIAL HOSPITAL  
ROCHESTER, NEW YORK 14642

DEPARTMENT OF MICROBIOLOGY

May 20, 1976

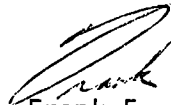
Dr. August G. Swanson  
Department of Academic Affairs  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D. C. 20036

Dear Gus:

I appreciate receiving the CAS Brief and wish to comment on two points. First, I am pleased to see the developments that have occurred in capitation. I think this will be an important contribution to stabilization of medical school funding. The specialty distribution is certainly appropriate in view of the "current perceived national needs". Second, I am appalled to see the continued onslaught against predoctoral training. I believe that the Association should continue to speak out against these curtailments.

Please advise me of your plans.

Sincerely,



Frank E. Young, M.D., Ph.D.  
Professor and Chairman

FEY:rj  
encl.

