



association of american medical colleges

MEETING SCHEDULE COUNCIL OF ACADEMIC SOCIETIES ADMINISTRATIVE BOARD

Washington Hilton Hotel
Washington, D.C.

January 12, 1977

5:00 p.m.	Business Meeting	<i>Grant Room</i>
7:30 p.m.	Cocktails	<i>Hamilton Room</i>
8:30 p.m.	Dinner	<i>Grant Room</i>

January 13, 1977

8:30 a.m.	Business Meeting	<i>Bancroft Room</i>
	Guests: <i>Mr. Stan Jones and Dr. David Blumenthal, Staff, Senate Health Subcommittee</i>	
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon and Executive Council Business Meeting	<i>Caucus Room</i>
4:00 p.m.	Adjourn	

1977 MEETING DATES

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

January 12-13, 1977

I. REPORT OF THE CHAIRMAN

II. ACTION ITEMS

1. Approval of Minutes of CAS Administrative Board Meeting
of September 15-16, 1976 1
2. All Items in Executive Council Agenda

III. DISCUSSION ITEMS

1. Report of the AAMC Officers' Retreat
(separate enclosure)
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5. Interim and Annual Meeting Plans 12
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IV. NEW BUSINESS

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

September 15-16, 1976

Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

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

Staff

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
Jack W. Cole

The CAS Administrative Board convened at 5:00 p.m. and adjourned at 7:30 p.m. for a social hour followed by dinner at 8:30. The meeting reconvened at 9:00 on September 16.

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting of June 23-24, 1976 were adopted as circulated.

II. Action Items

A. Ratification of LCME Accreditation Decisions

A total of 12 medical schools offered for Executive Council approval as accredited were listed in the Executive Council Agenda on pages 19-21. Three had received full accreditation by the LCME for a 7-year period (Yale, Cincinnati, and Washington (WAMI)); two had received full accreditation for a 4-year period (Mississippi and Nevada); three had received full accreditation for a 3-year period (California-Irvine, South Alabama, and Mayo); one had received full accreditation for a 2-year period (Texas-Houston); one had received full accreditation for a 1-year period (Stony Brook); and two had received provisional accreditation for a 1-year period (Uniformed Services and South Carolina).

*For part of the meeting
**Ex officio

In opening the discussion on this subject Dr. Hill remarked that the Administrative Board ratifies the LCME decisions on the basis that four of its members receive full reports on the individual school surveys, etc. and are well informed on their status. Dr. Bishop asked what the philosophy was behind the 1-year accreditation decisions, commenting that the accreditation paperwork takes the school about a year.

Dr. Swanson said that in the future he will have available at the meetings of the CAS Administrative Board the full accreditation report for any questions that may arise. Also he thought it might be a good idea to ask the four Board members who sit on the Executive Council if they could be prepared to answer specific questions that arise in the meetings with regard to individual schools. This responsibility could be shared among them on the schools likeliest to lead to queries.

ACTION: The CAS Administrative Board voted unanimously to ratify the LCME accreditation decisions.

B. Election of Institutional Members

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council approve for election by the AAMC Assembly as Institutional Members in the AAMC the University of South Alabama College of Medicine, the Mayo Medical School, the University of Minnesota-Duluth School of Medicine, and the Eastern Virginia Medical School.

C. Election of Provisional Institutional Member

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council approve for election by the AAMC Assembly as a Provisional Institutional Member in the AAMC the Uniformed Services University of Health Sciences.

D. Election of Members to the Council of Academic Societies

ACTION: The CAS Administrative Board voted unanimously to recommend to the Executive Council that the following be elected to membership in the Council of Academic Societies:

American Society for Clinical Nutrition
American Society of Clinical Pathologists

E. Election of Members to the Council of Teaching Hospitals

ACTION: The CAS Administrative Board voted unanimously to recommend to the Executive Council that the following be elected to membership in the Council of Teaching Hospitals:

Lankenaw Hospital (Philadelphia)
Mt. Sinai Hospital (Hartford)

F. Election of Corresponding Member

ACTION: The CAS Administrative Board unanimously approved the recommendation of the Veterans Administration Hospital (Boise, Idaho) as Corresponding Member.

G. Election of Individual Members

ACTION: The CAS Administrative Board unanimously approved election of the Individual Members listed in the Executive Council Agenda (Pages 27-28).

H. Election of Distinguished Members

ACTION: The CAS Administrative Board unanimously approved the election of the following individuals as Distinguished Service Members:

Stanley Ferguson
T. Stewart Hamilton

I. Election of Emeritus Members

ACTION: The CAS Administrative Board unanimously approved the election of the following individuals as Emeritus Members:

Kenneth Brinkhaus
Hugh H. Hussey
Thomas D. Kinney
Marcus D. Kogel

J. Approval of Subscribers

ACTION: The CAS Administrative Board unanimously approved the following as Subscribers:

University of Illinois - Peoria School of Medicine
University of Illinois - Rockford School of Medicine
University of Illinois - School of Basic Medical Sciences
(Chicago)
University of Illinois - School of Basic Medical Sciences
(Urbana)

K. Borden and Flexner Award Nominations

ACTION: The CAS Administrative Board unanimously approved the Borden and Flexner Award nominations. Additionally, if feasible the Board recommends the inclusion in the Annual Meeting Program of an announcement of the award winners' names and affiliations with a paragraph summarizing the achievements for which the award was made to each and a photograph of each.

L. Proposed Amendment to AAMC Bylaws

ACTION: The CAS Administrative Board considered at length the proposed amendment to the AAMC Bylaws that would seat on the Executive Council, in addition to the OSR Chairperson, an OSR Chairperson-Elect, who would be a voting member. The CAS Administrative Board unanimously voted to recommend instead that an OSR Chairperson-Elect be allowed to attend the meetings of the Executive Council for the purpose of improving the continuity of the OSR representation to the Executive Council but that the Chairperson-Elect be without vote.

M. JCAH Accreditation Manual for Hospitals: Medical Staff Standards

ACTION: The CAS Administrative Board instructed its representatives to the Executive Council to act in favor of the JCAH Accreditation Manual for Hospitals. The CAS Administrative Board took no official action on this matter.

MC. Council of Academic Societies Representative to Executive Council

ACTION: The CAS Administrative Board voted unanimously to recommend as its two nominations to fill its vacant seat on the Executive Council next term those clinical scientists who are currently on the CAS Administrative Board who will continue to serve on the Board next year. They are:

Daniel X. Freedman, M.D.
Thomas K. Oliver, M.D.

N. CAS Appointments to Group on Medical Education

ACTION: The CAS Administrative Board agreed that the matter of CAS appointments to the Group on Medical Education should be put on the Agenda of the CAS Business Meeting this fall so that the member societies can become better informed on their options and responsibilities in this regard.

O. AAMC Study of Faculty

Dr. Morgan elaborated on the summary of the AAMC Study of Faculty in the CAS agenda on page 12. The Board will offer supplemental criteria to the variables bearing on evaluation of faculty research performance. A revised listing of variables will then be sent to the Board who will be asked to rate the criteria.

ACTION: The CAS Administrative Board agreed to serve as an informal review or advisory committee to the AAMC Study of Faculty at least on a quarterly basis at the regularly scheduled Board meetings.

P. AAMC Position Statement on the Establishment and Official Recognition of New Specialties

ACTION: The CAS Administrative Board approved the statement presented. A Preamble which will clearly separate the issue of the boards from the recognition of new specialties is added to the statement.

Q. Issues for Consideration by the National Citizens Advisory Committee for the Support of Medical Education

Dr. Sherman reviewed for the Board the purpose in establishing the National Citizens Advisory Committee, the membership and the rationale behind the selection of its members. Dr. Clemente suggested that an excellent person for the Citizens Committee would be Mr. Chauncey Medberry, Chairman of the Board of the Bank of America.

ACTION: The CAS Administrative Board endorsed the appropriateness and the high priority of the issues delineated for the National Citizens Advisory Committee for the support of medical education.

III. Discussion Items

A. Clinical Research Training

Dr. Morgan discussed and invited comment on a draft distributed at the meeting on "Clinical Research Training." The Board agreed that research training should be supported as an essential part of faculty development. The Board discussed the feasibility of using data on fellowship trainees from the internal medicine study; of extending that study to pediatrics, psychiatry, and surgery; or of obtaining data from department chairmen.

Dr. Morgan will revise the draft, based on the Board's discussion. The Board agreed to review the next draft of the statement.

B. Legislative Workshop Meetings

According to Dr. Swanson, in the meetings held in July and September, representatives of constituent societies had reacted very enthusiastically to the legislative workshop proposed for December 1976. Primary purposes of the workshop were (1) to make newly designated individuals in the societies much more aware of how the federal legislative and regulatory processes work and (2) to make those persons more familiar with AAMC staff, CAS Administrative Board, and how the AAMC system works.

Dr. Bishop suggested that the CAS Administrative Board be invited to such future workshops.

From attendance records at regular meetings of the CAS, Dr. Clemente commented that we could ascertain those whose representatives had failed to attend and follow-up with some promotional phone calls. Dr. Swanson indicated that this had been pursued once in the recent past. He said that after the Annual Meeting the member societies

might be polled to ascertain their current concerns as a basis for effective, long-range program planning. Dr. Petersdorf added that the public affairs person should be an official representative of the Society with a long-term assignment so that he or she can become well informed. The Board offered suggestions on meeting sites that would be pleasant and easily accessible by plane.

C. Annual Meeting Plans

Several ideas for content of the CAS fall Business Meeting were made. In addition to the regular business, a review of the activities of CCME, LCGME, the status of the US-FMG, PL-1, new MCAT, and response to the President's Biomedical Research Panel, were some of the topics named as appropriate for discussion or else for inclusion as an agenda information item. Dr. Dodge said that an AAMC organizational diagram would be useful, as well as one for the CCME, LCME, LCGME, LCCME, etc. (the "rest of the alphabet soup"). He said he would like to have sufficient copies of the diagrams for every member of his Society.

Other items for inclusion were:

- Clinical research training
- Public affairs workshop
- Group on Medical Education Options
- COTRANS - Fifth Pathway
- P.L.-1 (Internships) - shortage in Primary Care specialties

IV. Information Items

A. Report of the CAS Nominating Committee

The Report of the CAS Nominating Committee appeared in the Agenda of the CAS Administrative Board on pages 20-21.

B. Status Report on Legislative Activities

Dr. Morgan briefed the Board on the status of the Confidentiality and Privacy Acts and of the Clinical Laboratory Act.

V. Adjournment

The formal meeting was adjourned at 1:00 p.m. for a joint luncheon meeting of the Administrative Boards of the CAS/COD/COTH/OSR.

NIH OVERSIGHT HEARINGS

Background

In 1974 Congress established the President's Biomedical Research Panel to appraise the state of the nation's biomedical/behavioral research enterprise. The Panel's Report was the result of 15 months of intensive study of the research effort and was a resounding endorsement of the NIH/ADAMHA programs. The Senate Health Subcommittee (Senator Edward Kennedy, Chairman) received the Panel's Report in June, 1976 at a hearing marked by heated interchanges. The Report was the opening presentation in a widely-heralded series of hearings on the oversight of NIH by the Congressional Health Subcommittees. Certain questions to the Panel and to DHEW/NIH witnesses who followed indicate that the Congress wishes to learn:

- 1) What has been the payoff to the public of its investments in medical science?
- 2) How responsive is the scientific community to the public in its selection of areas of research?
- 3) What is the responsibility of the research community for the transfer of new technology to health care and the cure of disease?
- 4) How do researchers feel social pressures in designing research projects?
- 5) What is the proper balance between basic and applied research supported by public funds?

Although answers to these questions were not in the basic charge of the President's Biomedical Research Panel, the Subcommittee persisted in efforts to obtain answers from members of the Panel.

Present Status

In the six months intervening since the Report was received, the Senate and House Health Subcommittees have been preoccupied with other concerns. Now, however, the Subcommittees indicate that the "oversight hearings" will resume early in 1977 as the Congress considers the renewal of a number of expiring health/biomedical research legislative authorities (e.g. Heart and Lung Act, research training authority). Indications are, also, that simple extensions of these acts will be proposed to give the Carter administration time to formulate its own plans; therefore, the "technology transfer" issue will likely be the item most often discussed in this Spring's hearings. Congressional staff have asked for AAMC assistance in refining the questions and addressing the problem.

Recommendation

The Administrative Board should consider ways in which the CAS can most effectively provide input to the hearings and legislative process. Should a task force be appointed to deal with this problem?

CLINICAL LABORATORY IMPROVEMENT ACT

Background

This Act died as time ran out on the last day of the 94th Congress but will be re-introduced in January, 1977. It has very important implications for clinical biomedical research. The bill would have required DHEW to license and set quality standards for clinical laboratories including standards for training of employees. Through efforts of CAS members and AAMC staff the original House language requiring licenses for individual physicians and for clinical research laboratories was modified. Physicians who perform their own laboratory work and research laboratories could be exempted from the bill's provisions upon application.

During the course of hearings on this bill CAS/AAMC gave testimony which emphasized the importance of the relationship of clinical laboratories to biomedical research. It pointed out to the Committee that biomedical research depends heavily on clinical research laboratories as well as basic science research laboratories. In research laboratories, as opposed to laboratories involved only in routine procedures, the personnel may have been trained not as clinical technicians or technologists, but rather for research. Therefore, they may not be professionally trained in clinical laboratory techniques, the training that would be required for employees of clinical laboratories by the bill. Our testimony also stressed that clinical laboratories involved mainly in research not only devise new procedures and tests for use in clinical laboratories, but that they set high standards of quality, competence and accuracy for the routine clinical laboratories. On this basis, the House Health Subcommittee was persuaded that those clinical laboratories that are entirely devoted to biomedical research should be provided with an exemption from the provisions of this bill.

A middle ground exists between those clinical laboratories involved mainly but not exclusively in research and those involved solely in routine clinical testing, and the Committee recognized the difficulty of creating regulations for those laboratories which provide clinical services while at the same time being involved with clinical research. The final version of the bill did resolve this problem satisfactorily but would have required licensing of such "mixed" clinical laboratories.

While the Congress was deliberating, the Department of Health, Education and Welfare, acting under existing authority, held hearings on an even more onerous set of regulations which would require all clinical research laboratories to be licensed, to be directed by board-certified specialists and to employ only graduates of clinical laboratory programs.

Clinical Laboratory Improvement Act
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Present Status

In early November AAMC staff met with Dr. James Dickson, DHEW Deputy Assistant Secretary for Health, to discuss the DHEW regulations. Apparently, DHEW is being urged to write tough regulations under the 1967 authority to control lab costs and to demonstrate to Congress that no new authority is needed.

On November 30, 1976, AAMC convened a task force of representatives from 12 societies to discuss ways to provide constructive input to DHEW and to Congress. The task force agreed that where patients are involved, results of clinical research laboratories must be assured by standards at least as stringent as, but different from, those applied to service laboratories. The task force will gather and transmit information to Congressmen, respond to the expected DHEW regulations when promulgated, and seek an amendment to the laboratory bill when re-introduced. The proposed amendment would allow the Secretary, DHEW, to deal differently with those research laboratories which also offer some services to patients.

CAS PUBLIC AFFAIRS WORKSHOP

During 1976 CAS societies expressed growing concern about increasing federal intrusion into all of the activities of academic medical centers. The societies expressed their desire for increased input into the legislative and executive process. In response to these wishes a Public Affairs Workshop was held in Palm Beach, Florida, December 12-14. The meeting was attended by more than 30 newly appointed representatives of the societies, who will assume primary responsibility for interfacing with their members and the AAMC in the arena of public affairs. Faculty for the workshop consisted of Ted Cooper, HEW Assistant Secretary for Health; Jay Cutler, Minority Counsel and Stan Jones, Staff Director, both of the Senate Health Subcommittee; Steve Lawton, House Health Subcommittee Counsel; Terry Lierman, Staff of the Senate Labor-HEW Appropriations Subcommittee; and John Sherman, Vice President of AAMC. Three former Congressional fellows, Margaret Heagarty and Charles Clark (R.W. Johnson fellows) and Art Silverstein (FASEB fellow) served as small group discussion leaders.

The objective of the workshop was to acquaint the Public Affairs Representatives with the intricacies of Congressional and Executive Branch procedures, including program initiation and regulation. After two days of small group sessions it was apparent that the objective had been accomplished and a high level of enthusiasm was evident from both participants and faculty. The next step is to identify areas of immediate concern to the societies for policy development and action.

The following is a list of representatives attending the workshop and societies represented.

<u>Representative</u>	<u>Society</u>
BIANCHINE, Joseph	Assn. Med. School Pharmacology
BRASEL, Jo Anne	Soc. Pediatric Research
CORNBLATH, Marvin	Assn. Med. School Pediatric Chairmen
CURTIS, Brian	Amer. Physiological Society
EDGERTON, Milton	Amer. Assn. Plastic Surgeons
GANT, Norman F.	Soc. Gynecologic Investigation
GILL, Thomas	Assn. Pathology Chairmen
GREENE, Nicholas	Assn. Univ. Anesthetists
HERSHEY, Solomon	Soc. Critical Care Medicine
HILL, Rolla	Assn. Pathologists/Bacteriologists
HOOPEs, John E.	Plastic Surgery Research Council
HOWARD, William A.	Amer. Academy Allergy
JOHNS, Thomas R.	Assn. Univ. Prof. Neurology
JONAS, Steven	Assn. Teach. Preventive Medicine
LYNCH, John B.	Am. Soc. Plastic/Recon. Surgeons
McCULLOUGH, Jeffrey	Acad. Clin. Lab. Phy. & Scientists
MISHKIN, Mark M.	Assn. Univ. Radiologists
MUNGER, Bryce	Assn. Anatomy Chairmen

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Representative

PAULY, John E.
RHAMY, Robert K.
SCHIFF, Gilbert
SCHULTZ, Richard
STAMP, Warren G.
STEINHAUS, John E.
SUGARBAKER, Everett
WEARY, Peyton
WEBSTER, Thomas G.
WELDON, Virginia V.

Society

Amer. Assn. Anatomists
Soc. Univ. Urologists
Central Soc. Clinical Research
Assn. Univ. Prof. Ophthalmology
Assn. Orthopaedic Chairmen
Soc. Acad. Anesthesia Chairmen
Assn. Academic Surgery
Assn. Prof. Dermatology
Assn. Acad. Psychiatry
Endocrine Society.

INTERIM AND ANNUAL MEETING PLANS

Interim Meetings

The Rules and Regulations of the CAS provide for an interim meeting. Prior to 1976 this meeting was usually held in February or March and consisted of a one-half day formal business meeting and a one-half day program on a selected topic. The overall experience with this format was poor. There was usually insufficient formal business requiring Council action to occupy the one-half day business meeting, and program topics selected months in advance were often not pertinent to the immediate concerns of the societies by the time of the meeting. Consequently, in 1976 the Administrative Board cancelled the previously scheduled and announced interim meeting, which was to be held in conjunction with the National Board of Medical Examiners annual meeting at the Bellevue-Stratford in Philadelphia.

In July and September, in order to sound out whether the societies would appoint a public affairs representative, two one-day meetings were held; one in D.C., the other in Chicago. Both were arranged so that an overnight stay would not be necessary. These meetings were informal, round-table discussions guided by a topics list, in part generated by canvassing the societies in advance regarding their concerns. The exchange of information and ideas was much more effective than in the previous format. At the end of the Chicago meeting, the representatives present indicated considerable enthusiasm for repeating this type of meeting in 1977.

It is proposed that in late June and mid-July two meetings, similar to the 1976 interim meetings, be held. The societies which have designated public affairs representatives will be particularly urged to sponsor these representatives to these meetings. Societies who have not designated such representatives will be asked to send a representative or an officer. The CAS Chairman and key AAMC staff will attend both meetings. Additionally, one or two Administrative Board members will be asked to attend a meeting.

The agenda will in part be based on current policy concerns emanating from Washington. In addition, the societies will be canvassed early and asked to identify areas of specific concern to them. These concerns will be collated and organized into the agenda within the limits of available time. No formal action will be taken at these meetings. Their purpose will be to provide communication between the CAS/AAMC and the societies.

Interim and Annual Meeting Plans
Page Two

Annual Meeting

The Executive Committee has proposed that the 1977 AAMC Annual Meeting focus on graduate medical education. A modification in the format of the meeting has freed-up an additional afternoon. This will permit the CAS to sponsor one or two afternoon programs of its own, targeting upon specific aspects of graduate medical education appropriate to the member societies, or it could cooperate with the Council of Deans and the Council of Teaching Hospitals in sponsoring one or two combined programs. The AAMC staff is in the process of developing possible program ideas and formats. Discussion of how the CAS should develop its program and interact with the other Councils is desired at this Administrative Board meeting.

CAS BRIEF

On the Monday following the January 12-13 Administrative Board meeting, topics for the Winter edition of the "CAS Brief" will be finalized. Ideas are needed for issues about which CAS society members should have prospective information.

REPORT OF THE
AAMC OFFICERS' RETREAT

December 15-17, 1976

Present: Dr. Ivan L. Bennett, Jr. - Chairman
Dr. Robert G. Petersdorf - Chairman-Elect
Dr. John A. Gronvall - COD Chairman
Dr. Julius R. Krevans - COD Chairman-Elect
Dr. A. Jay Bollet - CAS Chairman
Dr. Robert M. Berne - CAS Chairman-Elect
Dr. David D. Thompson - COTH Chairman
Mr. David L. Everhart - COTH Chairman-Elect
Dr. Thomas Rado - OSR Chairperson
Mr. Paul Scoles - OSR Chairperson-Elect

Ms. Judy Braslow	Dr. Richard Knapp
Dr. John A. D. Cooper	Dr. Thomas Morgan
Mr. Charles Fentress	Ms. Diane Newman
Dr. James Hudson	Dr. John F. Sherman
Dr. Paul Jolly	Dr. August G. Swanson
Dr. Thomas J. Kennedy, Jr.	Mr. J. Trevor Thomas
Mr. Joseph Keyes	Dr. Marjorie Wilson

I. Regionalization and Fractionalization of the AAMC

The issue of whether the AAMC is responding effectively to the needs of member (and developing) schools that have identified common and/or special interests and meet separately, appears to relate primarily to the Council of Deans.

There are four groups that have questioned their particular roles within the AAMC:

- The Deans of the Midwest-Great Plains Region
- The Deans of the Southern Region
- The Deans of New & Developing, Community-Based Medical Schools
- The Consortium of Thirteen Medical Schools

The first question was whether there was cause for concern. The officers concluded that wherever there was dissatisfaction the Association must be alert and sensitive, but that this particular set of concerns was of modest dimensions and called for greater attention and sensitivity to the interests of the groups, but no formal structural change in the Association. It was judged natural and predictable that alliances would form along the lines of commonly identified interests, but there was a clear consensus that it would be a mistake to translate such concerns into a new structural arrangement. To realign AAMC structure would tend to strengthen perceptions of separateness and result in an intensification of the problem rather than an easing of it.

The Council of Deans Administrative Board was asked to recognize this matter as a continuing concern and respond to it by appropriate attendance at regional meetings and efforts to keep lines of communication open. Dr. Krevans' intention to visit with the deans in advance of his assumption of the chair was regarded as a positive step in this direction. Staff involvement with these sub-groups should continue on an ad hoc basis with its level and intensity a matter of discretion and dependent on needs in particular situations.

II. Strengthening the OSR

Throughout OSR's history, there have been subtle as well as overt efforts on the part of other medical student groups to discredit the OSR at both the national and local levels. It was noted that OSR is particularly vulnerable to these efforts due to its relative lack of visibility at the local schools. The OSR-AAMC Bulletin Board, which is printed in a format suitable for posting on bulletin boards around the campuses, has not been an effective publication since few students have the opportunity or take the time to read it. Dr. Rado suggested that a quarterly newsletter distributed to all medical students in a format similar to the Weekly Activities Report or the CAS Brief would substantially heighten the awareness among medical students of the positive aspects of OSR. Although the OSR might achieve better recognition by medical students through such a publication, there would be severe logistical problems in distributing the newsletter which would have to be sent to the schools in bulk. Dr. Gronvall expressed the intent of the COD Administrative Board to work with the OSR Administrative Board during the coming year to pursue this idea and to develop other mechanisms for strengthening the OSR.

There was brief discussion about OSR's interactions with the other medical student groups. Dr. Rado indicated that the leaders of all four groups meet periodically to exchange information and share views but that there was no formal, binding agreement that would commit any of the groups to a particular course of action or would inhibit them from carrying out their separate roles. There was general agreement that OSR's liaison activities should remain informal and that efforts to strengthen the OSR should take priority over these activities.

Dr. Rado suggested that consideration be given to the establishment of an optional six-month internship program for the OSR Chairperson at the Association. He expressed the view that this would permit the Chairperson to devote more time and energy to OSR activities and would provide him or her with a unique opportunity to learn about academic medicine. Dr. Bennett indicated that this suggestion would be considered by the AAMC officers and staff during the coming year.

III. Relationship of Vice Presidents to AAMC

The issue was formulated as: Does the AAMC as currently structured have appropriate mechanisms for relating effectively to the Vice Presidents? Initial exploration reformulated the question as follows: Does the AAMC have adequate access to the officer who can speak for and commit the institution on matters of national policy? One approach suggested was that the deans be invited to bring with them to COD meetings, the Vice President or President or both for discussion of certain issues. In response, it was argued that interchange between such officials should take place in the private arena of the home institution rather than the public arena of the COD meetings.

Another formulation of the issue was: Does the AAMC have appropriate relationships with University Presidents? Many anecdotes referring to the Presidents organizations' involvement in the recent Health Manpower bill testified to the importance of this concern. There followed a discussion of developments within various national organizations involved in the processes of interest to the AAMC: the Federation of Associations of Schools of the Health Professions is in the process of developing a closer relationship to the American Council on Education; the Association of American Universities, with whom the Association had a close and effective relationship in the period 1969-71, is currently engaged in a reorganization of both its staff and constituent governance structure; the National Association of State Universities and Land-Grant Colleges, a more diverse group many of which do not have medical schools, currently has a joint ad hoc committee with AAU on Health Manpower legislation.

The officers concluded that the most appropriate approach for the Association would be to continue to develop appropriate relationships with these organizations, giving particular attention to: 1) exploring with the AAU means by which the previously productive relationship could be re-established; 2) encouraging the Federation and the ACE in their efforts to develop a more intimate relationship; and 3) working with the National Association of State Universities and Land-Grant Colleges in the development of policy positions.

IV. Housestaff Representation in the AAMC

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

There was agreement that the Association should continue to observe the housestaff situation which is currently dominated by complicated legislative and legal labor relations issues. Further, AMA/housestaff

relations should also be observed for a period of time. It was also noted that no formal request for representation had been received by the AAMC.

Because there are a variety of national and local issues which are currently under debate, the retreat participants agreed that the AAMC should seek qualified housestaff input to appropriate AAMC committees.

V. Update on FTC Accreditation Challenge

Dr. Cooper reported that both the AMA and AAMC had agreed to work closely and cooperatively on this issue. Together they had agreed to request a deferral of the Office of Education consideration of the LCME petition for recognition from the December meeting of the Commissioner's Advisory Group to the March 23-24 meeting. This deferral has been granted. Currently, the AMA General Counsel and the Association's attorneys are studying the background material in preparation for discussions regarding an appropriate response to the FTC challenge. Dr. Schofield, current Secretary of the LCME, has prepared a timetable for a development of this response, which has met with tentative agreement from those concerned.

In discussions of appropriate strategy to be pursued in this matter, the officers concluded that the challenge should be considered an attack on the LCME rather than either of the parent associations. Substantively, the response should not deal with allegations made regarding the interests or behavior of the AMA, but rather should argue that Congress contemplated a particular and ascertainable type of review when it established accreditation by recognized agencies as a prerequisite to Federal funding. The LCME was in existence then and has not been altered in ways which fundamentally change what Congress envisioned at the time of enactment. Thus, while the legislation calls for recognition by the Commissioner of Education, his responsibilities do not extend so far as to permit or require conditions or recognition which would fundamentally alter the nature of the process that the Congress mandated.

VI. Task Force on Graduate Medical Education

Graduate medical education is now a major responsibility of academic medical centers. The Executive Committee recommends that a task force be appointed and charged to review all the issues related to graduate medical education, and prepare a report detailing how graduate medical education should be organized in order to prepare physicians most effectively.

In accomplishing this task the issues surrounding accreditation, specialty certification requirements, financing, apportionment of residency positions among the specialties, relationships of house-

staff with faculty, and institutional responsibility should be thoroughly explored, both from the standpoint of their historical genesis and their future solution.

Broad input from the specialty boards and the specialty colleges and academies should be sought with a particular effort to obtain unpublished information having potential policy implications.

The task force effort should be given a very high priority. Staff augmentation might be provided by recruiting an individual with appropriate knowledge and interest to work with the staff for the task force on a part-time basis. An interim report of the task force should be provided at one of the functions of the Annual Meeting in November of 1977. A final report should be targeted for late 1978 or early 1979.

In addition to its primary charge, the task force should be utilized to advise the Association on all issues related to graduate medical education which require interim action during the task force deliberations.

VII. 1977 Annual Meeting

The Annual Meeting theme will focus on graduate medical education. Speakers for the plenary sessions will be chosen who are knowledgeable about the major issues facing academic medical centers in accomplishing their responsibility to ensure that graduate medical education is both of the highest quality and geared to the medical care needs of the nation. Councils and groups will be expected to target their programs, at least in part, on graduate medical education. The graduate medical education task force will provide an interim report.

The format for the 1977 Annual Meeting will be modified by combining the plenary session on the second day with the Assembly meeting, thus providing an additional one-half day for council and group programs.

VIII. Housestaff Collective Bargaining

A lengthy discussion of this issue was directed to the question of how the AAMC should respond to legislation introduced by Representative Thompson (D.-N.J.), Chairman of the House Subcommittee on Labor Management Relations, which would amend the National Labor Relations Act to cover housestaff as employees. The discussion was wide ranging and included reference to instances in which an appropriate educational environment does not exist and needs attention.

The possibility of attempting to add legislative language which would limit the items subject to negotiation or in some other fashion assert the preeminent educational process and objective of house staff programs

was also reviewed. It was generally agreed that the complex nature of house staff responsibilities and aspirations as well as differing medical specialty requirements made this option undesirable, if not infeasible.

The retreat participants agreed that the NLRB structure, process, and rules are inappropriate for purposes of dealing with what is essentially an educational process and a group of individuals whose aspirations are the advancement of educational qualifications. Therefore, it was recommended that the bill be opposed. It was also recommended that the tone, content, and clarity of any statements or testimony on this issue be carefully reviewed to convey the overriding educational concerns of the Association.

IX. National Health Insurance

The Report of the AAMC Task Force on National Health Insurance, approved in June, 1974, by the Executive Council, was reviewed as was recent legislative testimony based upon that Report. There was consensus that a new task force or committee to revise Association policy would not be necessary.

It was recommended that the Association retain its present statement on national health insurance, charging the staff to analyze the various proposals as they were introduced. Particular emphasis should be placed upon the implications of these proposals on the education and service programs of the academic medical centers. For example, if ambulatory care continues to be underfunded or not covered, the problems this would pose for educating more primary care physicians and providing more primary care services should be clearly articulated.

X. Implementation of Health Manpower Law

Dr. Kennedy summarized the process of promulgating regulations -- a three step process beginning with a Notice of Intent, followed by draft regulations, and ending with final regulations a minimum of 120 days after the publication of the Notice of Intent in the Federal Register. This entire process will be used for all thirty-two sets of regulations which need to be written unless the Assistant Secretary for Health obtains waivers because of time constraints.

Discussion followed regarding some of the more difficult problems which need to be solved during the regulation writing. These problems include how the "first year" should be defined, how to calculate "leakage" from primary care, and how "affiliation" should be defined. During the discussion on the definition of affiliation, there was disagreement on how the statutory language should be interpreted; and on whether, if there is flexibility in the statutory definition,

a broad or narrow definition would be most favorable to the medical schools. Consideration was given to whether or not the Association should survey the membership to gain some insight into the latter question, but no consensus was apparent.

Some time was also spent discussing the provision relating to the transfer of U.S. citizens enrolled in foreign medical schools to U.S. medical schools. Dr. Kennedy and Dr. Swanson summarized discussions with the Bureau of Health Manpower officials on this provision. It appears that this provision will have to be met in the fall of 1978, and the BHM hopes that voluntary admissions in the fall of 1977 will continue at or above present levels. Various options regarding the logistics of the matching process were discussed, though there was no agreement as to the best mechanism to be adopted.

Both Drs. Bennett and Gronvall indicated that they felt it important that the complexities of the legislation be transmitted to the constituency. Dr. Gronvall suggested that regional meetings attended by HEW staff, AAMC staff, and institutional representatives be held to discuss the law. This proposal appeared to have support among those who attended the retreat.

Another item which received extended discussion was whether or not the Association should support amending the bill in order to modify the requirement of placing U.S. citizens studying in foreign schools. Dr. Cooper summarized the pros and cons of such an action, including his perceptions of the feelings of both Senator Kennedy and Congressman Rogers. It is clear that Mr. Rogers will resist any amendment of this provision; if amending legislation is introduced, there is the very real probability that Senator Kennedy will push to modify the residency provisions in a manner unfavorable to the medical schools. The consensus of the retreat participants was that the Association should not seek to amend the bill, and that the hazards of such a move should be communicated to the membership.

The last issue discussed concerned restrictions on the granting of visas to foreign-trained physicians. Attention focused on equivalency to Parts I and II of the NBME and the criteria for waivers. Concern was also expressed regarding how the provision might disproportionately affect certain specialties such as anesthesiology and radiology. The staff was asked to explore ways in which temporary relief might be provided, either by designating an equivalent exam or by facilitating the waiver process.

XI. Health Systems Agencies

Late in the summer of 1975, the Association forwarded to the Director of the Bureau of Health Resources Planning and Development, recommendations for the development of regulations for the Health Planning and Resources Development Act, P.L. 93-641. That position, in summary,

recommended that, in general, funds for medical education and biomedical research should be exempted from the review process conducted by the Health Systems Agencies. That general recommendation was qualified with the suggestion that perhaps certain areas of graduate medical education and research programs with a significant service component might be reviewed by the Health Systems Agencies on a voluntary basis. The passage of a year's time since this position was adopted suggested that on the basis of experience developed within academic medical centers under the Planning Act a review of the position would be timely. As a result of the discussion at the retreat, there was a consensus that vigorous efforts should be made to assure explicit exemptions wherever possible. Difficulties with delays in the implementation of the legislation, with the complexities of the law, and the lack of influential involvement of academic medical centers in the local planning process were cited as strong justification for that position.

In the discussion on a related topic at the Retreat, there was unanimous concern that the composition of the Executive Committee of Health Systems Agencies and State Health Coordinating Councils frequently have no representatives from academic medical centers. As a consequence, the Executive Council will be asked to support the concept of amending P.L. 93-641, the Health Planning Act, to mandate such representation.

XII. Outlook for the 95th Congress

The discussion concerning the Outlook for the 95th Congress proceeded quite rapidly without too much time being spent on any one issue. The decisions made with regard to the specific pieces of legislation were as follows:

1. The National Cancer Act - The AAMC should oppose the renewal of this legislation and urge instead that the NCI revert to its previous status within the NIH. In addition it was felt that the AAMC should urge less specificity in the detail of legislation relating to biomedical and behavioral research. Since the CAS constituency seems to be split on this last point, it was decided to raise this question for discussion in January.
2. The Health Research and Health Service Amendments of 1976 - The Association should support a one year extension of the legislation and test the waters regarding modification during the biomedical research hearings. Two additional points were clearly made: it is probably unrealistic to expect a modification of the payback provision and it is probably inefficient to have the number of Heart, Lung and Blood Centers that currently exist.
3. The National Health Planning and Resources Act of 1974 - The Association should strive to include during renewal a mandated

membership requirement on the Executive Committees of the governing body of the Health Systems Agencies and on the statewide Health Coordinating Council which would ensure representation from academic medical centers.

4. Labor-HEW Appropriations - The Association should maintain its current method of operations which includes working both independently and in conjunction with the Coalition for Health Funding.
5. Supplemental Appropriations - The Association should take an active leadership role in securing full budget authority in FY 77 for the supplemental with emphasis being placed on the new health manpower legislation.
6. Clinical Laboratory Improvement Act - The AAMC should continue to urge the Congress to provide exemptions from the training requirements for those laboratories involved totally or partially in research.
7. Medicare and Medicaid Administrative and Reimbursement Reform Act - The AAMC should continue its current efforts to work closely with the subcommittee staff on this bill.
8. Social Security Amendments of 1972 - The Association should maintain its position taken in response to the IOM Report.
9. Federal Advisory Committee Act - The Association should support efforts to protect the confidentiality of the peer review process by amending the Federal Advisory Committee Act and the Freedom of Information Act as appropriate.

XIII. Personal Characteristics Assessment

The Executive Committee endorsed implementing a project to facilitate the assessment of the personal characteristics of students as they affect clinical performance. The primary effort will be focused on working with faculty in selected institutions to make more explicit the criteria that are used to evaluate the personal characteristics of students as they relate to clinical performance. More systematic approaches to applying these criteria in evaluating students will be developed and made available for utilization by the constituent institutions. This thrust is considered an essential first step if more sophisticated techniques are to be developed for selecting students on the basis of non-cognitive criteria.

XIV. Recruitment of Federal Health Officials

The problems and the desirability of recruitment and retention of highly competent individuals for mid and senior level positions in

Federal health agencies was recognized as deserving of the Association's attention, especially since academic medical centers are the best recruiting ground for such individuals. The discussion on this topic at the retreat included several suggestions in which the Association and its membership might contribute to the amelioration of this problem. The Association should continue to support proposals for more realistic salary scales for Federal health officials (such as that which President Ford is expected to forward to the Congress). It was felt that greater use to the mutual benefit of both Federal agencies and academic medical centers could be made of the Intergovernmental Personnel Act. This arrangement has the advantage that individuals temporarily in Government service can maintain their non-Government salaries and benefit packages. It was apparent that there was not widespread awareness of this authority or its specific provisions. Additional suggestions included the desirability of contacts with Carter transition staff members, especially concerning the retention of current Federal health officials. It was felt also that the Association could be of service to the new Administration in helping to convince current officials to remain or new individuals to come into Government.

XV. Process for Developing CCME Policy

The process for developing CCME policy received brief attention at the Retreat.

On the question of unanimity, there seemed to be recognition both of the fact that many individuals and organizations found the "veto" frustrating and the absence of a single voice to speak for the major organizations centrally concerned with medical education occasionally embarrassing. On the other hand, there was also recognition of the dangers inherent in the majority rule, and of the inescapable necessity that all major participants be in accord if major changes in policy or procedure were to be workable. The consensus was that the requirement for unanimity within CCME on policy issues be retained.

On the question of staffing, there seemed to be an agreement in principle on the desirability of an independent staff. On the other hand, exactly how it would work, to whom it would report, and how it would be financed did not receive extended discussion and debate. In general, some rotational scheme, perhaps among all five parent organizations, but more likely between two or three of them, seemed to be the way that most people would envision the system operating. There also seemed to be general agreement that an independent staff should support not only the CCME, but also the several Liaison Committees.

XVI. Renewal of Health Manpower Legislation

There was unanimous agreement that the best approach for the Association to take regarding the 1979 renewal of the Health Manpower bill was the appointment of an Association Task Force to consider possible legislative specifications. The Association should work closely with the national associations representing university presidents in developing these specifications.



**association of american
medical colleges**

A G E N D A

FOR

A A M C R E T R E A T

DECEMBER 15, 1976

TO

DECEMBER 17, 1976

BELMONT CONFERENCE CENTER

ELKRIDGE, MARYLAND

(301) 796-4300

A G E N D A

AAMC OFFICERS' RETREAT

Wednesday Evening, December 15

Cocktails 5:30 pm

Dinner 6:30 pm

Convene 7:30 pm - 10:30 pm

I. Regionalization and Fractionalization of the AAMC.	1
II. Strengthening the OSR.	3
III. Relationship of Vice Presidents to the AAMC.	4
IV. Housestaff Representation in the AAMC.	6

Thursday Morning, December 16

Breakfast 8:00 am - 9:00 am

Convene 9:00 am - Noon

(Coffee Break 10:30 am)

V. Update on FTC Accreditation Challenge (to be reported)	
VI. Graduate Medical Education	8
VII. 1977 Annual Meeting.	10
VIII. Housestaff Collective Bargaining	12

Thursday Afternoon

Lunch Noon - 1:30 pm

Convene 1:30 pm - 5:00 pm

(Coffee Break 3:30 pm)

IX. National Health Insurance.	14
X. Implementation of Health Manpower Law.	35
XI. Health Systems Agencies.	42
XII. Outlook for the 95th Congress.	48

*Thursday Evening
Cocktails 5:00 pm
Dinner 6:30 pm
Remainder of Evening Open*

*Friday Morning, December 17
Breakfast 8:00 am - 9:00 am
Convence 9:00 am - Noon
(Coffee Break 10:30 am)*

XIII.	Personal Characteristics Assessment.	54
XIV.	Recruitment of Federal Health Officials.	56
XV.	Process for Developing CCME Policy	57
XVI.	Renewal of Health Manpower Legislation	60

*Friday Afternoon
Lunch Noon - 1:00 pm
Adjournment 1:00 pm*

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1975-76 AAMC Annual Report (separate enclosure)	

REGIONALIZATION AND FRACTIONALIZATION
OF THE AAMC

ISSUE

Is the AAMC responding effectively to the needs of member (and developing) schools that have identified common and/or special interests and meet separately?

BACKGROUND

This issue relates to the existence of the following groups that express varying degrees of dissatisfaction with their role in the AAMC.

- The Deans of the Midwest-Great Plains Region
- The Deans of the Southern Region
- The Deans of New & Developing, Community-Based Medical Schools
- The Consortium of Thirteen Medical Schools

The Deans of the Northeastern Region and those of the Western Region do not meet on a regional basis, although various state or multi-state subgroups do exist to discuss or act upon local issues. In contrast, the Southern and Midwest-Great Plains Deans meet regularly (approximately twice a year) and a predictable feature of their meetings is a discussion of their perceived lack of participation//representation in the AAMC. While individuals from each of these geographic areas participate in the AAMC governance structure--Administrative Board and Executive Council--in numbers equal to or exceeding the other regions, (the Rules & Regulations require that nominations be made "with due regard for regional representation"), there are substantial numbers of individuals who feel that they have no effective role in the AAMC.

The most recent manifestation of this concern was a proposal considered by the Southern Deans to initiate a change in the AAMC governance structure to permit each region to elect their own representatives to the Executive Council. While this proposal was not adopted, a committee was appointed to study the problems and to make recommendations back to the Southern Deans.

It should be noted that the Groups, such as the GSA, and the OSR have regular regional meetings. The COTH sometimes meets for program sessions on a regional basis, as considered appropriate, in lieu of regular Spring meetings. The CAS has had Spring meetings in the past, but regional meetings are not appropriate to that Council's organization.

The Deans of New & Developing Schools was established in 1969 by Drs. DuVal and Hunt as an informal group of deans with common concerns not shared by deans from established institutions. The dean of the Rockford School of Medicine of the University of Illinois College of Medicine, a prominent member of this group, sponsored a meeting in 1972 of "Community-Based Medical Schools". A second meeting of the latter group was planned but was never held. In 1974, in recognition of the substantial overlap in the participants in these two groups, and in an effort to stimulate the participation of more experienced deans, the rule limiting membership to schools which had not yet graduated two classes of students was dropped and the name of the Deans of New & Developing Schools was expanded to include Community-Based Medical Schools. Additionally, a specific effort was made by the Chairman to include deans of subsidiary campuses and of schools which had not yet been accredited by the LCME. Because the group was self-identified, its activities self-initiated, and it included a substantial number of non-AAMC members, staff has played a relatively low-profile, liaison role. This limited role was in part designed to prevent the perception that the AAMC was being heavy-handed in limiting the activities of the group, in part to avoid AAMC intrusion into the affairs of institutions with satellite programs, and in part to avoid the appearance of AAMC support or sanction of institutions not yet accredited.

The Consortium of Thirteen Medical Schools is a group of private institutions self-identified as prestigious which meets several times annually to share approaches to mutual problems and concerns, e.g. in the area of admissions standards and procedures. The AAMC staff is not generally invited to nor informed about these meetings, but occasionally hears that its members consider that the AAMC is not sensitive to their particular needs.

Each of these groups may well be meeting needs that the AAMC is not well equipped to meet. They provide a forum for smaller group deliberations and do not require the sanction of the Executive Council for their activities. They do not make substantial demands on the AAMC budget. Generally, the groups are united by somewhat amorphous but identifiable interests and objectives. The concern is whether the AAMC is responding to their needs appropriately. Dr. Krevans' plan to speak with all or most members of the Council of Deans in groups of from 10 to 20 during the coming year is relevant to this discussion. His purpose is to learn as directly as possible what the deans' concerns and interests are with respect to AAMC/COD programs and operations.

QUESTIONS FOR CONSIDERATION

1. Should these groups be encouraged or discouraged in continuing their separate identity and meeting format?
2. Should the staff role be expanded to provide more direct support and assistance to these groups?
3. Should these groups be more directly linked to the AAMC governance structure? For example, should officers attend their meetings? Should regular reports be made to the Administrative Board and/or the Executive Council?

STRENGTHENING THE ORGANIZATION OF STUDENT REPRESENTATIVES

ISSUE

How can the OSR improve its visibility and general image among medical students?

BACKGROUND

Medical students currently have four national forums in which their representatives participate: The American Medical Student Association (AMSA), The Student National Medical Association (SNMA--specifically geared to black students), The Student Business Section of the AMA, and the OSR. Of these, the OSR is probably the least visible to medical students on campus. Few medical students have any understanding or appreciation of the AAMC or the role of the OSR within the AAMC.

This situation is complicated by the adverse publicity which the AAMC and the OSR have received in publications of other student organizations, most notably The New Physician. These criticisms have focused almost exclusively on the Association's role in health manpower legislation and in the NLRB ruling on housestaff status; they view the OSR as nothing more than a body to lend legitimacy to the Association's positions. Since The New Physician (published by AMSA) and Pulse (published by the AMA-SBS) circulate to every medical student, this impression of the OSR is intensified.

The other student organizations have questioned the value of the OSR, the effectiveness of its input, and the degree to which it represents medical students. Several schools have chosen not to appoint OSR representatives, expressing these same concerns. There was considerable support among the student representatives at the 1975 annual meeting for dissolving the OSR. However, the attitude in San Francisco in 1976 was overwhelmingly positive, with most of the students confident of the contributions which the OSR could make.

The OSR interrelates informally with the other student organizations, usually by means of a consortium meeting during the national meeting of each student group. This arrangement has remained informal despite some pressure from other student groups to turn it into a more structured policy deliberation.

QUESTIONS FOR DISCUSSION

1. Is the OSR valuable as a means of bringing student input to AAMC deliberations?
2. If so, how can the OSR strengthen its image among the medical students it seeks to represent?
3. What is the appropriate interaction between the OSR and other student organizations?

RELATIONSHIP OF VICE PRESIDENTS TO THE AAMC

ISSUE

Does the AAMC as currently structured have appropriate mechanisms for relating effectively to the Vice Presidents?

BACKGROUND

A perennial organizational concern is the appropriate relationship of Vice Presidents of Health Affairs to the AAMC. Clearly persons holding these positions have substantial influence over the future of academic medicine. Just as clearly, however, they do not fit neatly into the present organizational structure of the Association. This matter was recently reopened by two events: 1) the proposal by the AAMC Task Force on Governance and Structure that it be given the mandate to undertake a thorough examination of the AAMC organization, building on the Coggeshall Committee study and specifically examine the issue: "How can the AAMC better represent the chief executive of the academic medical center who is often not the dean?"; 2) the Southern Deans considered a proposal offered by the Texas Deans that there be established a Council of Academic Administrators in the AAMC for the chief executive officers.

The Executive Council declined to provide the Task Force on Governance and Structure with the mandate it sought. The Southern Deans substituted a motion urging more intense interaction between the AAMC and the AAHC for the Texas Deans' proposal that a new council be established. The substitute motion was defeated by a wide margin. Thus, there is no outstanding proposal that requires a specific response. Nevertheless, the fact that the matter continues to be raised indicates the desirability of continued reexamination.

Alternative organizational arrangements which might permit a formal recognition of the Vice Presidents' role and facilitate participation in the AAMC have been developed in the past, but there has never been a proposal for formal consideration. The present AAMC approach to this issue is reflected in the renaming of the previous "Senior Member" category as "Distinguished Service Member" and specifying the objective of this group as providing a means of continued participation in AAMC affairs to those who had once been active in a constituent council, and who, by virtue of a change in their organizational responsibilities are no longer eligible for such service. A major consideration in the establishment of this group was the objective of providing Vice Presidents, who were previously deans, with a forum for continued participation in the AAMC.

In discussions with AAMC leaders, many of the Vice Presidents, (including Association for Academic Health Centers officers) expressed the feeling that they could not appropriately relate to an association representing a single profession. Since their responsibilities transcended medicine, they envisioned no specific role for the Vice President within the framework of the AAMC. The AAHC is theoretically structured to have parallel relationships with all of the MOD-VOPP health professional groups.

QUESTIONS FOR CONSIDERATION

1. Is the AAMC weakened by not having representation from "the chief executive officer of the academic medical center who is not (may not be) the dean"? If this is a concern, how should it be pursued? Alternatives which have been suggested include:
 - a. Maintain the status quo, keeping close liaison with the Association for Academic Health Centers and possibly developing AAMC programs which include other health professions (possibly utilizing the Federation). Continue to invite Vice Presidents to participate on AAMC task forces and committees.
 - b. Authorize a thorough study on the magnitude of the Coggeshall committee study of the mid-sixties. Recommendations on Association reorganization and function might then necessitate the equivalent of a "constitutional convention".
 - c. Establish a separate Council of Vice Presidents (or Council of Health Center Executives) with AAMC programs responding to the inter-professional interests of the Council.
 - d. Expand the Council of Deans to a Council of Institutional Representatives with dual representation from each institution. Members would include the chief executive officer and the chief academic officer of each medical center (certified when necessary by a Credentials Committee).
2. Is the provision of a forum for formerly active deans (now V.P.s) an appropriate objective of the Distinguished Service Membership? If so, is it accomplishing that objective satisfactorily? How can the prospects for achieving the objective be enhanced? Or is the Distinguished Service Membership quite another kind of forum, i.e., one of elder statesmen who concentrate on considerations of a very broad policy nature?
3. Does the AAMC relate most effectively with Vice Presidents on an interorganizational basis, AAMC to AAHC? Is the current modus operandi of that relationship appropriate and effective? (AAMC President and Chairmen invited to their meeting, AAHC President and Executive Director invited to our Executive Council meeting?)

HOUSESTAFF REPRESENTATION IN THE AAMC

ISSUE

Should the AAMC actively seek to develop a mechanism for housestaff representation in the Association?

BACKGROUND

The Association of American Medical Colleges is dedicated to the advancement of medical education. Through its current organization and governance structure the AAMC is able to serve as a forum for the interest of medical school deans, faculty, teaching hospital executives, students and other professionals in the areas of medical education, patient care and research. It has been pointed out by representatives of the OSR, as well as other interested observers and participants, that in order to further the Association's capacity to more adequately represent all components of the medical center, consideration should be given to some form of participation of house officers in the affairs of the Association. The argument has been advanced that since the AAMC has endorsed the concept of the continuum of medical education and university responsibility for graduate medical education, housestaff participation becomes even more important. No direct request for representation from individual house officers or housestaff organizations has been received since November 1970.

In addition, the Association has increasingly found itself in an adversarial position with the existing housestaff organizations. The Physicians National Housestaff Association (PNHA) has organized formally as a union and seems less concerned with educational issues than with "hours and wages." Any AAMC involvement with housestaff should probably be limited to issues of an educational nature.

OPTIONS

1. This activity may be considered inappropriate or of low priority at this time.
2. Direct representation within the AAMC could be achieved by providing a separate seat for house officers on the AAMC Executive Council. No other organizational structure would be established.
3. Providing housestaff representatives with a seat or seats on either the CAS or COTH Administrative Board would provide a mechanism for communicating their respective views to the AAMC Executive Council. A position on the AAMC Executive Council could also be made available. Again, in this case, no further organizational structure would be required.

4. A Group on Housestaff Affairs could be organized in a manner similar to the current groups which function in the areas of medical education, student affairs, public relations, business affairs and planning.
5. Creation of an Organization of Housestaff Representatives (OHR), reporting to or through either the Council of Teaching Hospitals or Council of Academic Societies, with a seat on the Executive Council, is a format similar to that which presently exists in the AAMC Organization of Student Representatives.
6. House officers could be organized along the lines of the OSR, and the two could be combined into a new Conference of Junior Colleagues reporting directly to the AAMC Executive Council with two seats on that Council.

Options 2 and 3 would require a process of selecting representatives. One way to accomplish this is to request various organizations--PNHA or AMA Interns and Residents Sections--to submit at least four names from which the AAMC Executive Council could make a selection.

Options 4, 5, and 6 would require the development of a more complicated organizational development on a teaching hospital or medical center basis with housestaff representatives chosen at the local level using procedures similar to those currently in effect for the OSR.

GRADUATE MEDICAL EDUCATION

ISSUE

In 1968 the Council of Academic Societies sponsored a major national conference on the Role of the University in Graduate Medical Education. In 1971 the Association issued a position statement calling for institutional responsibility for graduate medical education. In 1976 the Congress required that to qualify for capitation, the medical schools must significantly intervene in graduate medical education. How far have the academic medical centers progressed in assuming responsibility for graduate medical education? What are the impediments?

BACKGROUND

Graduate medical education, prior to World War II, was for most physicians a one-year internship. Education as a specialist was sought by comparatively few. Both the internship and specialty training developed as on-the-job training in hospitals, and for specialty education the focus was on the program and the control was with the program director. The expansion of graduate medical education after World War II built upon this model.

In 1966 the Millis Commission called for more institutional responsibility for graduate medical education. Subsequent to the CAS Conference in 1968, a committee report setting forth the implications of institutions assuming graduate medical education responsibility was published in 1971, and in 1973 the Graduate Medical Education Committee published "Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education." A survey conducted in the spring of 1974 demonstrated that only three academic medical centers had achieved all of the criteria set forth in the guidelines, nineteen others had achieved some of the criteria, and thirty indicated a definite interest.

In 1972 the LCGME was created and in 1975 it began to accredit graduate programs. The Coordinating Council, in 1974, issued a position statement on institutional responsibility for graduate medical education. However, modifying the review and approval process for accreditation to put an emphasis on institutional responsibility has not yet been accomplished.

Now, in 1976, the academic medical centers have been given a Congressional mandate to be the agencies responsible for assuring that at least fifty percent of graduate medical education is in the primary specialties. At the end of a decade of discussion of academic medical centers being the institutional entities responsible for grad-

uate medical education, it is appropriate to focus the year's activities and the Annual Meeting theme on this topic.

PROPOSAL FOR DISCUSSION

A task force should be appointed to review the status of graduate medical education in the U.S. with particular emphasis on the state of development of institutional responsibility, but it should also be charged to look at issues in accreditation, financing, certification requirements for specialty training, educational program development, and specialty distribution. The task force should assist in planning input to the COD spring meeting, to the CAS interim meetings, and the COTH interim meeting; and finally to develop a series of presentations for the Annual Meeting, the theme of which might be Graduate Medical Education.

It is recommended that the task force be composed of eleven members--two COD, two CAS, two COTH, two GME Section on Graduate Medical Education, one OSR, and two house staff.

1977 ANNUAL MEETING

SUGGESTED THEME

At the 1976 Annual Meeting, Eli Ginzberg called graduate medical education "The soft underbelly of medical education", referring to its quiet evolution and current methods of financing it from patient care dollars. It is proposed that the Association devote the entire 1977 annual meeting to an examination of graduate medical education. One Plenary Session would be devoted to speakers on various aspects of the topic, while other sessions organized by the councils or outside organizations could be devoted to a particular aspect. It is also proposed that the Assembly meeting be combined with the second morning Plenary Session, with two thematic speakers invited (in addition to the Assembly's usual brief business).

Speech topics for the Plenary Session might include as many as six of the following:

1. Quality Control and Accreditation
2. Institutional Responsibility Ten Years Later
3. GME Opportunities and Controls--Numbers and Specialty Distribution
4. Maintenance of the Broad First Year
5. GME Opportunities and Controls--Foreign Graduates and the Future Role of the ECFMG
6. The Medical School--Teaching Hospital Partnership in GME
7. Developing New Settings for GME
8. Current and Alternate Methods of Financing GME
9. Implications of Housestaff Collective Bargaining

ANNUAL MEETING FORMAT

The 1977 Annual Meeting will be at the Washington Hilton Hotel, Washington, D. C. on November 5 - 10. With the Assembly meeting combined with the second Plenary Session, there will be an extra afternoon free for programmatic sessions. In addition, the first Plenary Session can be held one day earlier in the meeting, thus taking place at a time when the most people are present.

SAT	SUN	MON	TUES	WED	THURS	
	OSR Groups Societies	PLENARY	PLENARY ASSEMBLY	Programs Groups Societies RIME	Groups Societies RIME	A.M.

OSR	OSR Groups Societies Programs	Councils Business Meetings	Council Programs; RIME Conf.	Programs Groups Societies RIME	Groups Societies RIME	P.M.

QUESTIONS FOR RETREAT CONSIDERATION

1. Theme?
2. Which speech topics seem most appropriate?
3. Should political speakers be invited as well (thus reducing the number of thematic presentations)? Note that political speakers might be difficult to get on Tuesday, November 8--local election day.
4. Retreat participants should begin suggesting speakers for the Plenary Sessions, Alan Gregg Memorial Lecture--this must be finalized by the January Council meeting.

HOUSESTAFF COLLECTIVE BARGAINING

ISSUE

What position should the AAMC take on legislation to expressly define housestaff as employees under the National Labor Relations Act?

BACKGROUND

In June 1974, the National Labor Relations Act was amended to include under the Act all non-public health care institutions. While the amendments added provisions to the Act to facilitate the application of federal labor law to health care providers, the issue remained as to whether housestaff were to be treated as hospitals employees covered by the Act.

In 1975, the National Labor Relations Board consolidated five cases in COH hospitals concerning the application of the Act to housestaff. Because the Board's decision would have a significant impact upon graduate medical education, the AAMC Executive Council decided that the Association would not be fulfilling its obligation to maintain the standards of medical education unless it asserted the educational nature of intern and residency positions and opposed any action which would make the structure and function of graduate medical education subject to an adversary process of labor negotiations. The Executive Council authorized the submission of an amicus curiae brief to the NLRB; the written brief was filed in April 1975 and oral arguments presented in September 1975.

In March 1976, the National Labor Relations Board ruled on the Cedars-Sinai and St. Christopher's cases. The Board held (with one member dissenting) that housestaff are primarily engaged in graduate educational training programs and, therefore, were not to be considered employees for purposes of coverage under the National Labor Relations Act. In his lone dissent, Board member Fanning asserted that the housestaff perform a service for the hospital and receive compensation. Challenging the majority opinion, he noted that the key element "...has always been whether students were also employees." As a result of the Board's decision, housestaff cannot claim the protection of the National Labor Relations Act in disputes with teaching hospitals, although housestaff may seek to organize and bargain outside the framework provided by the Act.

The Physicians' National Housestaff Association and its related groups were dissatisfied with the NLRB's decision, and PNHA announced its intention to fight the decision "on all fronts." Included in subsequent PNHA efforts have been appeals to Members of Congress, especially Representative Frank Thompson (D.-N.J.) who is Chairman of the House Subcommittee on Labor-Management Relations, to amend the National Labor Relations Act to cover housestaff as employees. PNHA also provided vocal and visible support to President-Elect Carter.

In October 1976, Representative Thompson introduced a bill to amend the National Labor Relations Act to cover:

"(b) any employee, including any intern, resident, fellow, or other such trainee in a professional training program who is receiving a stipend or compensation for work performed in connection with such program or for performing related work described in clause (ii) of this paragraph, who (i) has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a), and (ii) is performing related work under the supervision of a professional person to qualify himself to become a professional person or a professional employee as defined in paragraph (a)."

Representative Thompson is expected to introduce this, or a substantially similar, bill in the new Congress.

OPTIONS

1. The Association could launch an all-out effort to defeat any legislation designed to define housestaff as employees under the National Labor Relations Act. To be politically acceptable, such action would probably have to be based on arguments similar to those used in the NLRB amicus brief--that residents occupy positions in educational programs which should not be subject to the adversary process of labor negotiations. Additional arguments might include the fact that inclusion of one group of "student-employees" will likely lead to efforts by other groups (e.g., dietary interns, laboratory technician interns, etc.) to gain recognition as employees under the Act, and the fact that the Health Manpower Act has made medical schools accountable for the distribution of housestaff positions by specialty.
2. The Association could accept the concept of defining housestaff as students and employees under the Act and could attempt to add legislative language which would limit the items subject to negotiation. Such a position would require distinguishing educational functions of residency training which would not be subject to negotiations from employment functions of residency training which could be subject to negotiations.
3. The Association could accept the concept of defining housestaff as students and as employees under the Act and, following the Ontario experience, could attempt to define the employer of housestaff to include medical faculty and third-party payers as well as the hospital corporation.

NATIONAL HEALTH INSURANCE

ISSUE

In light of the election of Jimmy Carter and his avowed intention of enacting a national health insurance program which is comprehensive, universal, and mandatory, should the AAMC revise its 1974 policy statement on national health insurance?

BACKGROUND

In 1973, the Association appointed a task force, comprised of James F. Kelly, Ph.D., Chairman; Ray E. Brown; Jack W. Cole, M.D.; Merlin K. DuVal, M.D.; John M. Stagl; Ernest Turner; and Robert L. Van Citters, M.D., to revise the AAMC's policy statement on national health insurance. After many months of meetings and several drafts of the task force report, a modified report was adopted by the Executive Council as AAMC policy in June 1974. A copy of this report follows.

The difficulty in achieving consensus on national health insurance policy reflected the many divergent views of the AAMC members. Task force members ranged from supporters of the Kennedy Health Security Act to advocates of no national program. As a result of these divisions, the AAMC policy makes no recommendation on the means of financing the system. The position does, however, address all of the aspects of national health insurance particularly affecting medical education and the teaching hospital.

In mid-1975 the Association appointed a review committee to discuss a draft CCME statement on national health insurance and to recommend any necessary changes in the AAMC position. The committee recommended that the current statement be retained, since it addressed all of the particular concerns of the academic medical center. It was felt that, coupled with the CCME statement, the AAMC position provided a firm base from which testimony could be drafted. A copy of the final CCME statement and the Association's 1975 testimony is included in the agenda after the task force report.

President-Elect Carter has emphasized and endorsed the following statements from the 1976 Democratic Party Platform:

We need a comprehensive national health insurance system with universal and mandatory coverage. Such a national health insurance system should be financed by a combination of employer-employee-shared payroll taxes and general tax revenues. Consideration should be given to developing a means of support for national health insurance that taxes all forms of economic income. We must achieve all that is practical while we strive for what is ideal, taking intelligent steps to make adequate health services a right for all our people. As resources permit, this system should not discriminate against the mentally ill.

National health insurance must also bring about a more responsive consumer-oriented system of health care delivery. Incentives must be used to increase the number of primary health care providers, and shift emphasis away from limited-application, technology-intensive programs. By reducing the barriers to primary preventive care, we can lower the need for costly hospitalization. Communities must be encouraged to avoid duplication of expensive technologies and meet the genuine needs of their populations. The development of community health centers must be resumed. We must develop new health careers, and promote a better distribution of health care professionals, including the more efficient use of paramedics. All levels of government should concern themselves with increasing the number of doctors and paramedical personnel in the field of primary health care.

Ultimately, the shaping of a national health insurance system will be an involved political process. Key policy leaders in this area--President-Elect Carter and unnamed members of his Administration; Representatives Ullman, Rostenkowski, and Rogers; Senators Long, Talmadge, and Kennedy--have as yet shown no inclination toward any type of consensus. Various proposals will undoubtedly surface with little more likelihood of speedy enactment than in past years. It is impossible to anticipate whether the new Administration will be able to gain the widespread cooperation which will be needed to pass any form of health insurance.

OPTIONS

1. The Association could retain its present statement on national health insurance, charging the staff and officers with analyzing the various proposals and preparing testimony based on the current position.
2. The Association could establish a task force to revise the AAMC statement on national health insurance issues.
3. The Association could establish a task force to review and evaluate specific national health insurance proposals using present or revised AAMC policy statements as a preliminary step in developing testimony.
4. The Association could attempt to develop a specific national health insurance proposal elaborating on the AAMC policy statements. If introduced as legislation, such a proposal could provide visibility to educational and manpower issues and would promote participation in Congressional hearings.

REPORT

AAMC TASK FORCE ON NATIONAL HEALTH INSURANCE

Introduction

The Association appointed the AAMC Task Force on National Health Insurance to revise the Association's policy statement on national health insurance dated February 18, 1971, in light of renewed Congressional interest in the issue. The members of the Task Force included Chairman James F. Kelly, Ph.D., Ray E. Brown, Jack W. Cole, M.D., Merlin K. DuVal, M.D., Baldwin G. Lamson, M.D., Alexander Leaf, M.D., G. Thomas Shires, M.D., John M. Stagl, Ernest Turner, and Robert L. Van Citters, M.D.

In its work, the Task Force first examined the present method of health care financing in the United States, assessed its deficiencies, and then determined what distortions in the present system of health care delivery were caused by the present system of health care financing. In light of these findings the Task Force proceeded to develop a set of recommended positions on various national health insurance issues. This report sets forth the Task Force's findings and recommendations.

Findings

According to a recent Social Security Administration study, health spending in the United States in 1973 reached \$94.1 billion. Funds to finance this health care bill came from three sources: 1) from individuals, as personal

out-of-pocket medical expenditures; 2) from various forms of public or private insurance; and 3) from the general revenues, collected from taxpayers. In 1973, three-fifths of the nation's health care bill was paid from private sources, and two-fifths came from public sources. Total national expenditures for personal health care (excluding among other things expenditures for insurance premiums) totaled \$76.5 billion in 1972 (the latest year for which data are available). Private health insurance met 25.5% of this amount, 35.6% came from direct out-of-pocket payments by consumers, and 37.5% was met by public funds.

Although health insurance met 42% of all consumer expenditures for personal health care in 1972, many individuals remained uncovered by any form of health insurance. In 1972, an estimated one-fifth of the population under age 65 had no financial protection against the hazards of illness. Still larger numbers had inadequate coverage. Three-fourths of the population had private insurance protection against some of the cost of hospital and surgical care; and 72% were covered for some of the cost of inpatient physician's visits and outpatient radiologic and laboratory examinations; about 55% were covered for any part of their expenditures for prescription drugs, private duty nursing or visiting-nurse services; 22% for any nursing home care; and less than 9% for any dental care.

These statistics illustrate that the portion of the health care bill which the individual must now pay directly as a personal expenditure is large. The purpose of a national health insurance program is to transfer a large part of this personal financial responsibility to the insurance function. Most of the financial risk of illness should be shared by all in an approximately equal way through the insurance mechanism.

The major purpose of national health insurance legislation, then, is to create a better means of financing medical care. Although national health insurance per se may not effect a drastic restructuring of the health care delivery system, it should promote needed changes. To define and then bring about the ideal delivery system is too great a task to be accomplished in a single step. Yet national health insurance should both permit and strongly encourage changes in the present delivery system.

Accordingly, the Task Force makes the following findings of deficiencies in the present system of health care financing:

- (1) It acts as a barrier to accessibility to needed health care services.
- (2) It leaves too many uncovered costs to be borne inordinately by the individual as personal out-of-pocket expenditures.
- (3) It promotes and perpetuates a two-class system of patient care.
- (4) The insurance component, unlike other insurance, does not cover the highest risks first, and often does not cover them at all.

Further, the Task Force makes the following findings of distortions in the present health care delivery system under the present health care financing mechanisms:

- (1) It interferes with professional judgment as to the use of expensive patient care where less expensive patient care would be appropriate.
- (2) It offers few incentives for efficiency.
- (3) It does not stimulate changes in the present delivery system.
- (4) It does not provide the risk capital necessary for innovation.
- (5) It stimulates the disproportionate distribution of health care resources to more affluent areas.

(6) It provides inadequate financing for the provision of health services to the poor.

(7) It provides inadequate incentives for distributing physicians by specialty according to the needs of society.

In light of these findings, the Task Force takes the following positions on the specific national health insurance issues of scope of coverage, structure of covered benefits, consumer responsibility for cost-sharing, methods of financing the insurance system, regulation of the underwriter, regulation of providers, standards for provider reimbursement, development and distribution of resources, and effect on other programs.

Scope of Coverage

Because adequate health care has come to be recognized as a right and not a privilege of all Americans, any national health insurance system should have as its first priority the provisions of health insurance coverage for all. This goal of universal coverage will be attained by requiring as a matter of law not only that the opportunity to obtain adequate health insurance coverage must be made available to each individual, but also that he must take advantage of this opportunity. Voluntarism will never produce universal coverage, for there will always be those who will opt out due to ignorance, undue optimism, or neglect. A national health insurance program which does not provide universal coverage will unquestionably perpetuate the two-class system of patient care it is designed to eliminate, as afflicted individuals without health insurance protection will have to be treated on a charity basis.

Benefit Structure

A national health insurance plan should finance the most comprehensive package of health care benefits within the resources available. As a general rule, all necessary health care expenditures should be covered without quantity limits. Exclusion from coverage should be well-defined and well-reasoned. All exclusions should be periodically reviewed and re-evaluated in light of new federal initiatives and new developments in health care management and delivery. Any exclusion from coverage should fit into one of the following categories:

- (1) Services for which insufficient personnel and facilities exist for provision on a universal basis should be excluded. It would be irresponsible for the national health insurance legislation to create health care expectations that the delivery system could not meet.
- (2) Services not traditionally included in an individual's personal health care expenditures, and financed instead through general revenues as public health care expenditures, although important to good personal health, should initially be excluded from coverage under national health insurance. Because long-term care for chronic mental illness, for example, is most often provided in state-operated institutions supported by public funds, this care would most efficiently be provided with federal assistance and in accord with federal quality standards through a separate state-operated system. The Medicaid program, which now finances long-term custodial care in nursing homes in many states, should

be modified to have as its primary purpose the provision of this kind of care in accord with federal quality standards in all states for individuals who cannot pay for it as a personal health care expenditure.

- (3) Benefits which, if included, would pose unreasonable administrative burdens should be excluded from coverage under the national health insurance system.

Except for services excluded for these reasons, covered services should include, at a minimum and without limit, hospital services (including active treatment in psychiatric hospitals), physician services and other appropriate professional and paramedical services wherever provided, and diagnostic laboratory and diagnostic and therapeutic radiologic services wherever provided. Other covered benefits should include wherever provided such services as home health services, rehabilitation services, cost-beneficial preventive services, emergency medical services, and crisis-intervention mental health services.

Cost-sharing

A program of national health insurance is designed to provide ready financial access to the health care system and to shift the financial burden of health care from personal expenditures to insurance coverage, thus broadening the financial base available to support health care costs. The ideal health insurance program should therefore have no cost-sharing provisions. If a particular health insurance proposal includes such cost-sharing mechanisms as deductibles, coinsurance, or copayments, they should be held to minimum levels, and their effect on utilization should be evaluated. They should only be high enough to avoid over-utilization; they should not be

burdensome in the aggregate to a family; they should be waived for low-income persons. Furthermore, they should not be applicable to essential minimum services, and the cost of administering the cost-sharing should not exceed the savings from avoided over-utilization. In addition, if a national health insurance plan utilizes cost-sharing, the provider, in order to promote efficiency, should not be involved in collecting the patient's share. The provider should not be required to determine at the point of delivery whether or not the patient has met cost-sharing obligations in the past or whether the patient can pay any new cost-sharing obligations that may arise.

Financing the Insurance System

The present system of health care financing leaves significant population groups without health insurance protection, and even larger groups with inadequate coverage. The individual's personal, out-of-pocket health bills too often exceed his financial ability to meet them and act as a barrier to needed care. Health insurance should meet more of the individual's health care expenses. The method used to finance the national health insurance system should mandate universal coverage and make certain that individuals are not caught in gaps of coverage with changes in employment or financial status. Each and every citizen must be assured of a uniform minimum package of benefits.

Regulation of the Insurance Underwriter

Regardless of the extent to which private health insurance is to be included in a national health insurance program, the federal government has a responsibility for safeguarding the public by effectively regulating the private insurers. Such regulation will be most effective if done by a single federal agency, independent of the agency charged with administering

the national health insurance program, which will license, monitor, and otherwise regulate all health insurance underwriters. This agency should also be charged with the duty to promulgate standards governing carrier solvency, risk-selection, loss ratios, and premium rates.

Regulation of the Provider

Any regulation of the relationship between the underwriter or the intermediary and the provider must assure that the standards by which providers are reimbursed for their services are not only economically prudent but also fundamentally fair. Because there are substantial area-to-area variations, the regulation of provider reimbursement and health care costs would best be performed at the state or substate level under strong federal guidelines. Regulatory decisions in these areas must be rendered with due process, equity, and fairness, and there should be an effective mechanism for the appeal of such decisions.

Provider Reimbursement Standards

Any national health insurance system must establish a reimbursement policy which allows fair and reasonable payments for services and which stimulates efficiency and cost constraints as consistent with the promotion of high quality medical care.

A fair and reasonable reimbursement policy for physician services should provide payment for high quality professional medical services on an equal basis irrespective of the setting in which the services are provided. Such a reimbursement policy should not impede the training and education of medical students and residents, and should recognize the team approach to professional

care in the teaching setting. The policy should not, for example, in setting conditions under which fee-for-service reimbursement of teaching physicians is to be made, require the kind of financial test and other conditions imposed by section 227 of the Social Security Amendments of 1972.

A reimbursement policy which is fair and reasonable also will meet the financial needs of the institutional providers of the services, including the replenishment of capital for the maintenance of an up-to-date facility. Allowable expenses for reimbursement under a national health insurance program should include the depreciation of capital assets, the amortization of debt, and the accumulation of an adequate operating margin. Furthermore, the reimbursement policy should reflect that there are valid differentials among the various types of providers in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: 1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; 2) the comprehensiveness and/or intensiveness of services provided by the teaching hospital; and 3) the teaching hospital's commitment to the incremental cost of providing the environment for medical and paramedical educational programs.

A reimbursement policy that stimulates efficiency and cost constraints consistent with the promotion of high quality medical care will not only mandate that the providers institute effective utilization review and quality control programs. It will also provide for an organized system of research and development of methods to insure that quality control and utilization control standards will be determined and implemented only on a valid statistical basis. Furthermore, because provider efforts to regulate and monitor quality

and utilization are costly propositions, the cost of any such regulatory measure should be justified by its effectiveness and then treated as any other allowable cost for the purpose of reimbursement.

Resource Development and Distribution

While national health insurance should not be expected to correct all of the distortions in the present health care delivery system caused by the current system of health care financing, neither should its reimbursement policies encourage further distortions.

National health insurance is an appropriate mechanism for financing graduate medical education as a means of replenishing the health manpower pool. Graduate medical training includes important elements related to education and delivery of health services as integral parts of the training, and is thus appropriately financed by the health delivery system, both with respect to inpatient and ambulatory care. In its financing of graduate medical education, the national health insurance system may justifiably be used to influence the numbers and kinds of medical generalists and specialists that are trained. The problem of specialty distribution is currently under study by the Coordinating Council on Medical Education and the Institute of Medicine, and the findings and recommendations of such studies should be carefully considered in developing a method for dealing with the problem.

Similarly, national health insurance is an appropriate mechanism to assure the construction of resources that meet community needs. The special need for facilities for the education and training of health professionals by the medical schools and teaching hospitals must be given proper recognition in these determinations. The kind of approach to this problem taken by Section 1122

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of the Social Security Act, which provides that providers constructing facilities determined to be unnecessary by a state's designated planning agency are not to receive federal reimbursement for depreciation and interest on those facilities, should be extended to reimbursements under a national health insurance program. Planning agencies should be strengthened to perform this additional function.

Philanthropy

Philanthropic contributions have provided non-profit and public hospitals with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and for innovative programs. This vital support has stimulated research and development in medical care organization.

Any program of national health insurance should recognize and encourage the contribution of philanthropy to the health care system. More specifically the tax system should continue to provide deductions from corporate and individual income taxes for charitable contributions. Second, hospital reimbursement formulas should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. Finally, expenditures of funds derived from philanthropy should be under the control of the governing board of the respective hospital subject only to the control of the state planning agency.

Effect on Other Federal Programs

The federal government should have a coherent, rational, and unified role in the financing of health care. To date, public health care funds have been

channeled into a variety of inadequate or overlapping federal programs, and the resulting fragmentation has been both costly and inefficient. Accordingly, separate federal programs that now exist, such as the Veterans Administration health care system, Public Health Service hospitals, the Indian Health Service, and the military dependents program, should be integrated into the national health insurance system. This integration will best be accomplished gradually, but nonetheless in accordance with a fixed timetable. To this end, the first priority should be the standardization of all benefits provided through all existing public programs to conform to the national health insurance benefit package standard. As this is accomplished, the other aspects of the separate public health care programs should be modified and meshed into the national health insurance system. If a program cannot feasibly be modified for integration into the national health insurance scheme, it should be gradually phased out.

RECOMMENDATIONS OF THE
JOINT CCME/LCGME COMMITTEE ON
FINANCING GRADUATE MEDICAL EDUCATION

- I. The costs of approved programs of clinical postdoctoral education in teaching institutions shall be included as allowable costs (a cost of doing business) for purposes of reimbursement from all sources. The recognition of the costs of such approved programs in clinical postdoctoral education as allowable costs shall be acknowledged and paid by all purchasers of services for health care. The allowable costs of clinical postdoctoral education include, but are not limited to, the stipends and related costs of clinical postdoctoral trainees (residents and fellows) and payment to supervisors and teachers for educational activities, and are applicable to both inpatient and outpatient services, as well as costs of space, equipment, and supplies. Revenue from grants, endowments and other funds restricted by the donor to clinical postdoctoral medical education should be deducted from total costs prior to determining reimbursement costs.
- II. Reimbursement mechanisms should provide for and encourage clinical postdoctoral medical education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory care must include the additional cost of clinical postdoctoral education in the ambulatory setting including facilities, space and equipment as well as personnel.
- III. The manner and amount of stipends and related costs for clinical postdoctoral residents and fellows shall be left to local option.
- IV. Financing and reimbursement policies should provide support for modification of programs in clinical postdoctoral medical education through the appropriate expansion of existing programs and the development and addition of needed new programs, and should facilitate the elimination of programs which no longer fulfill the aims of education or needs of patient care.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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STATEMENT BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ON NATIONAL HEALTH INSURANCE*

Mr. Chairman and members of the Committee:

I am Charles Womer, Chairman, Council of Teaching Hospitals of the Association of American Medical Colleges and Director of Yale-New Haven Hospital. The Association represents all of the nation's medical schools, sixty-two academic societies and 400 of the nation's major teaching hospitals. Our membership is thus deeply involved in both the provision of high quality medical services and the education and training of future physicians. The Association is not supporting any specific proposal presently before the Subcommittee, nor do we offer specific proposals.

I am submitting a more detailed statement of the Association's views on national health insurance for the Subcommittee's consideration and for inclusion in the record of the hearing.

*Presented by Charles Womer, Director, Yale-New Haven Hospital to the Subcommittee on Health, Committee on Ways and Means, House of Representatives, November 6, 1975.

This morning I will limit my remarks to a discussion of the Association's policy positions in the areas of health manpower, physician and hospital reimbursement, and the role of philanthropy as they relate to national health insurance.

HEALTH MANPOWER

National health insurance is an appropriate mechanism for financing graduate medical education - that is, the training of interns and residents - as a means of replenishing the health manpower pool. Public and private insurance programs as well as other patient care revenues are currently the predominate sources of financing graduate medical education and other hospital-based educational programs and should not be jeopardized. This method of financing graduate medical education has been historically applied both to inpatient and ambulatory or outpatient services. However, this financing has been much more adequate in the case inpatient services than it has been for outpatient services. During the past several years, there has been substantial pressure, and subsequent institutional commitment to provide a greater amount of educational experience in ambulatory settings and to produce more primary care physicians. Generally, these commitments have been made without sufficient attention to longer range financial considerations. For example, under the Manpower Act of 1971, a large number of family practice residency programs are being supported by federal grant awards. In the absence of

such awards, I seriously doubt these programs would survive.

The financing of all educational programs in the ambulatory setting is a difficult problem, and one which has not received the attention I believe it deserves. Facing continuing large deficits in the operation of their ambulatory services and diminishing ability to cover these losses from other revenue sources, teaching hospitals cannot significantly expand their ambulatory educational and service programs without adequate reimbursement for them. We would be happy to discuss it further with you when there is more time available than we have this morning.

In its financing of graduate medical education national health insurance may justifiably be used to influence the numbers and kinds of medical generalists and specialists that are trained. The problem of specialty distribution is currently under study by the Coordinating Council on Medical Education and the Institute of Medicine. The findings and recommendations of such studies should be carefully considered in developing methods for achieving a balanced supply of specialists which matches the public's needs for services.

PHYSICIAN AND HOSPITAL REIMBURSEMENT

Any national health insurance system must establish reimbursement policies which allow reasonable payments for services, and which stimulate efficiency and cost constraint consistent with the production of high quality medical services.

Teaching Physician Reimbursement

A fair and reasonable reimbursement policy for physician services should provide payment for high quality medical services on an equal basis irrespective of the setting in which the services are provided. Such a reimbursement policy should not impede the training and education of medical students and residents, and should recognize the team approach to medical care in the teaching setting. The policy should not, for example, in setting conditions under which fee-for-service reimbursement of teaching physicians is to be made, require the financial tests or similar requirements imposed by Section 227 of the Medicare Amendments of 1972. This entire issue is under study, at the direction of the Ways and Means Committee in 1973, by the Institute of Medicine. The Association and its constituent institutions have actively cooperated in the development of this study, and I urge your thorough review of the final report when it becomes available in March of 1976.

Teaching Hospital Reimbursement

Payments to institutional providers must reflect the fact that there are valid differences among the various types of hospitals in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; (2) the comprehensiveness and/or intensiveness of services provided by the teaching hospital; and (3) the teaching

hospital's commitment to the incremental cost of providing the environment for medical and paramedical educational programs.

One of the most troublesome issues before us today is the manner in which Section 223 of the 1972 Social Security Amendments has resulted in an inappropriate classification of hospitals for reimbursement purposes. We outlined our views concerning this matter to this Subcommittee in June of this year and again in September. I will not take your time to do so again this morning. These views and a proposal which we submitted in September are available on the record, and again I want to express our willingness to discuss this matter further at any time.

PHILANTHROPY

Finally, I would like to turn to an important area which must be given careful attention in national health insurance deliberations. Philanthropic contributions have provided hospitals and medical schools with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and innovative programs. This vital support has stimulated research and development in medical care organization, as well as research in the biomedical sciences. The Association urges that members of this Subcommittee continue to recognize and encourage the contribution of philanthropy to the health care system. The tax system should continue to provide deductions

from corporate and individual taxes for charitable contributions. Additionally, hospital reimbursement policies should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. In some state rate control programs, and indeed during the Federal Economic Stabilization Program, hospitals are being and have been threatened with failure to provide rate increases until after an institution's reserves and unrestricted endowment are depleted. The use of privately donated funds to meet operating costs is not a policy which encourages philanthropic giving. We recommend specific language be included in any national health insurance program to protect and encourage private philanthropy for health care institutions.

I have only highlighted our views, and have chosen to limit my remarks to a few narrow, but very difficult problems in the interest of brevity.

Thank you very much for permitting me the opportunity to testify before you on these very important issues. I will be happy to answer any questions you may have.

IMPLEMENTATION OF THE HEALTH MANPOWER LAW

ISSUE

What are the major AAMC concerns relating to implementation of the Health Professions Educational Assistance Act of 1976, P.L. 94-484? How and to whom should these concerns be voiced?

BACKGROUND

On October 12, 1976 President Ford signed P.L. 94-484 into law. This culminated three years of effort by Congress to pass an extension of the Comprehensive Health Manpower Training Act of 1971. Despite passage of a detailed piece of legislation, the impact of many provisions critical to the medical schools will depend upon the interpretive power of the regulation-writers in DHEW. The Association has three ways in which to affect this process: (1) provide input and insight to DHEW officials prior to the development of the regulations (now!); (2) comment on the regulations when they appear in the Federal Register; (3) seek legislative or judicial redress if unacceptable regulations are ultimately issued.

Obviously, the earlier the Association can participate in this process, the greater the likelihood of success. The Association is in a very good position to help DHEW try to implement this complex law. Several major provisions of the law heavily dependent on administrative interpretation are discussed below and the text of the specific provisions follows.

1. Capitation Condition Involving First Year Primary Care Residencies

To qualify the schools for capitation, a percentage of all filled "first year" positions in "direct or affiliated medical residency training programs" must be in "primary care." The percentage requirements are 35% for FY 1978, 40% for FY 1979, and 50% for FY 1980. If the aggregate goal is not met on July 15 of the previous year, each school seeking capitation will be responsible for individually meeting the same goal as of July 15 of the fiscal year in which funds are sought. In determining these percentages, the Secretary is instructed to subtract "leakage" equal to the number of individuals who were in a qualified first-year position one year previously and who were no longer in a "direct or affiliated medical residency training program in primary care" (at the same school, when calculating individual percentages).

Despite the specificity of the provisions, several ambiguities remain to be defined in regulations.

1. How should the "first year" be defined?
2. How should training programs in "general internal medicine" and "general pediatrics" be defined and identified?

3. How should "direct or affiliated programs" be defined? Should VA affiliations count?
4. How will the leakage actually be calculated?

2. Capitation Condition Involving Transfers of U. S. Foreign Medical Students

To qualify for capitation, each school must agree to reserve positions for U. S. citizens enrolled in a foreign medical school prior to October 12, 1976 who have successfully completed two years of medical school and passed NBME Part I. The Secretary "shall equitably apportion a number of positions adequate to fill the needs" of such students. However, a school does not have to enroll a particular student if: (1) the student does not meet entrance requirements, other than "academic qualifications" or place of residence; or (2) enrollment would jeopardize accreditation; or (3) the Secretary grants a waiver due to the lack of clinical facilities or patients. Although it is difficult to predict how many students can qualify for this apportionment, the AAMC staff estimates that it could be as many as 800 per year.

The law states that these positions must be reserved "in the school year beginning immediately before the fiscal year for which such grant is applied for...." Steve Lawton strongly urges that this means enrollment beginning in the 1977 entering class.

In view of this provision's fundamental intrusion into academic decision-making and the admissions process, and in view of the deans' unanimous condemnation of the provision, the AAMC must consider the possibility of urging amendment of the law. However, political realities and potential hazards must be weighed. Senate staff has indicated that Senator Kennedy might entertain such an amendment, but that a re-opening of the bill would likely produce other amendments. It is reported that Senator Kennedy would like to make compliance with the primary care condition tougher, possibly raising the percentage, changing the calculation, and/or removing the aggregate goals. On the House side, Mr. Rogers apparently will strongly oppose any amendment deleting the USFMS provision.

1. Should this provision be re-examined by the Congress, despite the hazards of paving the way for other amendments?
 - a. If so, which approach to amending the law should the AAMC support?
 - i) complete repeal of the condition;
 - ii) tie capitation to a requirement to apply for a specific project grant to educate these students; only schools actually receiving such awards would be required to enroll the students, who would be selected through the schools' normal transfer procedures;

iii) provide bonus capitation awards for voluntary acceptance of these students (e.g., \$4,000 per transfer student above the regular capitation support of \$2,000 per student.

2. If amendment is undesirable or unsuccessful, how might the regulations best preserve non-academic inquiry (such as interviews, assessment of motivation and interests, etc.)?
3. How detrimental to the schools would it be for this provision to take effect with the 1977 entering class (in effect, conditioning capitation on a decision which would have to be made 14 - 18 months prior to the receipt of that capitation)?

3. Health Manpower/Health Planning Overlap

Section 1513(3) of the National Health Planning and Resources Development Act of 1974, P.L. 93-641, provides that the area Health Systems Agency is to review and approve or disapprove of the proposed use of federal funds for health programs within its jurisdiction. However, funding under Title VII of the Public Health Service Act (which includes all but one medical manpower program authorized by P.L. 94-484) is not reviewable by the HSA unless the grants or contracts involved are "to support the development of health resources intended for use in the health service area or the delivery of health services." It is an important implementation issue as to what manpower programs will have to be reviewed under this provision of the planning law. Construction grants are almost certain to be reviewed, but the list of other programs that may be subject to review (e.g., training grants in family medicine) is sufficiently long that some guidance from HEW will be required. HEW must allow the HSA sixty days for its review and HEW cannot approve a grant or contract disapproved by the HSA, unless the state agency has a chance to comment. If HEW approves a program denied a grant by an HSA then both the HSA and the state agency must receive a detailed explanation of HEW's approval. While many of the grants and contracts entered into under P.L. 94-484 programs will probably receive pro forma approval from the HSA's, the process is time consuming and cumbersome.

1. Should the Association seek to limit HSA review to the fewest number of programs under this authority or is some other guideline more appropriate?

4. Immigration of Foreign Medical Graduates

Title VI of the manpower law amends the immigration statutes to remove physicians from preference status, to require passage of Parts I and II of the National Boards and English competency prior to entry, and to restrict J-visas to individuals having a training agreement from an accredited school and involved hospitals. The J-visa restrictions have

particular implications for the teaching hospitals. Under these restrictions, the trainee would have to pass Parts I and II (or an equivalent as determined by the HEW Secretary) before the school could enter into the required training agreement. The trainee must make a commitment to return to the "country of his nationality or last residence" after two years, although this may be extended one year for training purposes.

The State Department has issued a communique to all embassies notifying them that, as of January 10, no visas are to be granted unless these requirements are met. Those currently in this country or having received J-visas before November 1 are exempted. Trainees receiving J-visas between November 1 and January 9 must enter the country by January 9.

At present, the NBME examination is not normally administered abroad and there appears to be no way a foreign national could qualify for the J-visa unless sponsored by a school to take the NBME exam in this country. The law has no phasing-in provisions, although there is a broadly worded waiver of these J-visa restrictions if a "substantial disruption" of a program's health services can be shown to result.

1. Should the Association ask the Secretary to declare temporarily that the ECFMG examination is equivalent to Parts I and II of the National Boards?
 - a. If so, for how long?
2. Should the Association actively spur the involved agencies (DHEW, NBME) to develop a more desirable long-range solution, such as overseas administration of the National Boards or development of a new qualifying examination?

grant applied for is to be made will not be less than the first-year enrollment of such students in the school in the preceding school year or in the school year beginning in the fiscal year ending September 30, 1976, whichever is greater; and

"(2) the applicant will expend in carrying out its functions as a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.

Ante, p. 2290.

"(b) (1) **MEDICAL SCHOOLS.**—To be eligible for a grant under section 770 each school of medicine shall, in addition to the requirements of subsection (a), meet the applicable requirements of paragraphs (2) and (3).

"(2) (A) (i) Unless, as determined under subparagraph (B), the number of filled first year positions on July 15, 1977, in direct or affiliated medical residency training programs in primary care is at least 35 percent of the number of filled first year positions on that date in all direct or affiliated medical residency training programs, to be eligible for a grant under section 770 for the fiscal year ending September 30, 1978, a school of medicine shall have on July 15, 1978, at least 35 percent of its filled first year positions, as determined under subparagraphs (C) and (D), in its direct or affiliated medical residency training programs in first year positions in such programs in primary care.

"(ii) Unless, as determined under subparagraph (B), the number of filled first year positions on July 15, 1978, in direct or affiliated medical residency training programs in primary care is at least 40 percent of the number of filled first year positions on that date in all direct or affiliated medical residency training programs, to be eligible for a grant under section 770 for the fiscal year ending September 30, 1979, a school of medicine shall have on July 15, 1979, at least 40 percent of its filled first year positions, as determined under subparagraphs (C) and (D), in its direct or affiliated medical residency training programs in first year positions in such programs in primary care.

"(iii) Unless, as determined under subparagraph (B), the number of filled first year positions on July 15 of any year (beginning with 1979) in direct or affiliated medical residency training programs in primary care is at least 50 percent of the number of filled first year positions on that date in all direct or affiliated medical residency training programs, to be eligible for a grant under section 770 for the fiscal year ending on September 30 of the following year, a school of medicine shall have on July 15 of such following year at least 50 percent of its filled first year positions, as determined under subparagraphs (C) and (D), in its direct or affiliated medical residency training programs in first year positions in such programs in primary care.

"(B) The Secretary shall determine what percent of all the positions filled, as of July 15, 1977, and July 15 of each subsequent year, in all direct or affiliated medical residency training programs are filled positions in such programs in primary care. In determining the number of such positions in primary care on July 15, 1977, or on July 15 of a subsequent year, the Secretary shall deduct from such number a number equal to the number of individuals who were in a first year

position in any direct or affiliated medical residency training program in primary care as of July 15 of the previous year and who on the date for which the determination is to be made were not in any direct or affiliated medical residency training program in primary care. Each determination under this subparagraph shall, not later than 45 days after the date for which the determination is made, be published in the Federal Register and reported in writing to each school of medicine in the States and to the Committee on Interstate and Foreign Commerce of the House of Representatives and to the Committee on Labor and Public Welfare of the Senate.

"(C) In determining if a school of medicine meets an applicable requirement of clause (i), (ii), or (iii) of subparagraph (A) for a fiscal year, the number of filled first year positions in direct or affiliated medical residency training programs of such school in primary care on July 15 in such fiscal year shall be reduced by the number of individuals who were in a first year position in a direct or affiliated medical residency training program of such school in primary care on July 15 in the previous fiscal year and who on July 15 in the fiscal year to which the requirement applies were not in a direct or affiliated medical residency training program of such school in primary care. Each determination, with respect to a school, under this subparagraph shall, not later than 45 days after the date on which the determination is made, be reported in writing to such school and to the Committee on Interstate and Foreign Commerce of the House of Representatives and to the Committee on Labor and Public Welfare of the Senate.

"(D) The requirement under subparagraph (A) that a school of medicine have a particular percent of its filled first-year positions in its direct or affiliated medical residency training programs in primary care on a date in order to be eligible for a grant under section 770 shall be waived by the Secretary if he determines that (i) such school has made a good faith effort to comply with such requirement, and (ii) such school has at least 98 percent of such percent of such positions in primary care on such date.

"(E) The Secretary shall not make any grant under section 770 to a school of medicine for any fiscal year if the Secretary, after providing notice and opportunity for a hearing, determines that in the fiscal year such school—

"(i) terminated or failed to renew an affiliation with a medical residency training program for the purpose of meeting the requirements of this paragraph, and

"(ii) after such a termination or failure to renew, provided support for such medical residency training program (including any interchange of medical residents, students, or faculty between the school and such program, the offering of any faculty position at such school to any individual on the staff of such entity who has any responsibility for such program, or the provision or receipt by such school of any funds for such program).

"(F) For purposes of this paragraph:

"(i) The term 'direct or affiliated medical residency training program' means a medical residency training program with which a school of medicine is affiliated or has a similar arrangement (including any arrangement which provides for any interchange of medical residents, students, or faculty between the school and such program, the offering of any faculty position at such school to any individual on the staff of such entity who has any responsibility for such program, or the provision or receipt by such school of any funds for such program), as determined under regulations of the Secretary, or which is primarily conducted in facilities owned by a school of medicine.

Determination: publication in Federal Register; report to medical schools and congressional committees.

Determination: report to medical school and congressional committees.

Ante, p. 2290.

Notice, hearing.

Definitions.

Primary
Care
Condition

"(ii) The term 'primary care' means general internal medicine, family medicine, or general pediatrics.

"(iii) The term 'medical residency training program' means a program which trains graduates of schools of medicine and schools of osteopathy in a medical specialty and which provides the graduate education required by the appropriate specialty board for certification in such specialty. Such term does not include a residency training program in an osteopathic hospital.

Ante, p. 2290.

USFMS
Condition

"(3) (A) To be eligible for a grant under section 770 a school of medicine shall, in its application for such grant, give assurances satisfactory to the Secretary that, except as provided in subparagraphs (C) and (D), the school will reserve positions, in the school year beginning immediately before the fiscal year for which such grant is applied for for students described in subparagraph (B).

"(B) No later than August 15, 1977, and August 15 of each of the next two years, the Secretary shall identify the citizens of the United States who, before the date of enactment of the Health Professions Educational Assistance Act of 1976, were students in a school of medicine not in a State and who by the date of the identification made under this subparagraph—

Ante, p. 2243.

"(i) successfully completed at least two years in such school of medicine, and

"(ii) successfully completed part I of the National Board of Medical Examiners' examination (or any successor to such examination).

The Secretary shall equitably apportion a number of positions adequate to fill the needs of students described in subparagraph (B) among the schools of medicine in the States.

"(C) A school of medicine shall not be required to enroll a student described in subparagraph (B) if—

"(i) the individual does not meet, as determined under guidelines established by the Secretary by regulation, the entrance requirements of the school (other than requirements related to academic qualifications or to place of residence), or

"(ii) enrollment of such individual will, as determined by the Secretary after consultation with the appropriate accreditation body, result in the school's not meeting the accreditation standards of such body.

Waiver.

"(D) The Secretary may waive the requirements of this paragraph upon a finding that, because of the inadequate size of the population served by the hospital or clinical facility in which such school conducts its clinical training, compliance by such school with such assurances will prevent such school from providing high quality clinical training for the students added by the application of this paragraph to such school.

"(c) SCHOOLS OF OSTEOPATHY.—(1) To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of osteopathy shall, in addition to the requirements of subsection (a), submit to the Secretary and have approved by him before the grant applied for is made, a plan to train full-time students in ambulatory care settings, in the school year beginning in the fiscal year for which the grant is made and in each school year thereafter beginning in a fiscal year for which such a grant is made, either in areas geographically remote from the main site of the teaching facilities of the applicant (or any other school of osteopathy which has joined with the applicant in the submission of the plan) or in areas in which medically underserved populations reside.

"(3) An application of a school of podiatry shall contain or be supported by assurances satisfactory to the Secretary that, for the school year beginning in the fiscal year for which a grant is made under section 770, at least 40 percent of the enrollment of full-time, first-year students in such school will be comprised of students who are residents of States in which there are no accredited schools of podiatry.

Ante, p. 2290.

"(i) SCHOOLS OF PHARMACY.—To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of pharmacy's application for such a grant shall, in addition to the assurances required by subsection (a), contain or be supported by assurances that each student who is enrolled in the school will before graduation undergo a training program in clinical pharmacy, which shall include (1) an inpatient and outpatient clerkship experience in a hospital, extended care facility, or other clinical setting; (2) interaction with physicians and other health professionals; (3) training in the counseling of patients with regard to the appropriate use of and reactions to drugs; and (4) training in drug information retrieval and analysis in the context of actual patient problems."

TECHNICAL AND CONFORMING AMENDMENTS

42 USC 295f-6,
295f-2.

SEC. 503. (a) Section 775 is redesignated section 772 and is amended—

(1) by striking out "section 770, 771, 772, or 773" each place it occurs and inserting in lieu thereof "section 770" in subsections (a) and (d) and "section 770 or subsection (a) or (b) of section 778" in subsection (b),

(2) by inserting ", public health" after "dentistry" in subsection (b),

(3) by striking out "this part" in subsection (c) and inserting in lieu thereof "section 770",

(4) by striking out "section 770, 771, or 773" in subsection (d) (1) and inserting in lieu thereof "section 771", and

(5) by amending subsection (d) (3) to read as follows:

"(3) provides for such fiscal control and accounting procedures and reports, including the use of such standard procedures for the recording and reporting of financial information, as the Secretary may prescribe, and access to the records of the applicant, as the Secretary may require to enable him to determine the costs to the applicant of its program for the education or training of students."

(b) Sections 312 and 313 are repealed.

(c) The amendments made by this section shall take effect October 1, 1977.

Repeal.
42 USC 244-1,
245a.
Effective date.
42 USC 295f-2
note.

TITLE VI—FOREIGN MEDICAL GRADUATES

LIMITATION ON IMMIGRATION OF FOREIGN MEDICAL GRADUATES

FMG
Restriction

SEC. 601. (a) Section 212(a) of the Immigration and Nationality Act (8 U.S.C. 1182(a)) is amended by (1) striking out the period at the end thereof and inserting a semicolon in lieu thereof, and (2) by adding at the end thereof the following new paragraph:

"(32) Aliens who are graduates of a medical school and are coming to the United States principally to perform services as members of the medical profession, except such aliens who have passed parts I and

II of the National Board of Medical Examiners Examination (or an equivalent examination as determined by the Secretary of Health, Education, and Welfare) and who are competent in oral and written English. The exclusion of aliens under this paragraph shall apply to special immigrants defined in section 101(a)(27)(A) (other than the parents, spouses, or children of United States citizens or of aliens lawfully admitted for permanent residence), to nonpreference immigrant aliens described in section 203(a)(8), and to preference immigrant aliens described in section 203(a)(3) and (6)."

(b) Section 101(a)(15) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)) is amended as follows:

(1) Subparagraph (II)(i) is amended by inserting before the semicolon ", and who, in the case of a graduate of a medical school coming to the United States to perform services as a member of the medical profession, is coming pursuant to an invitation from a public or nonprofit private educational or research institution or agency in the United States to teach or conduct research, or both, at or for such institution or agency".

(2) Subparagraph (II)(ii) is amended by inserting before the semicolon ", but this clause shall not apply to graduates of medical schools coming to the United States to perform services as members of the medical profession".

(3) Subparagraph (II)(iii) is amended by inserting before the semicolon ", other than to receive graduate medical education or training".

(4) Subparagraph (J) is amended by inserting "and who, if he is coming to the United States to participate in a program under which he will receive graduate medical education or training, also meets the requirements of section 212(j)" before ", and the alien spouse".

(c) Section 212(e) of such Act (8 U.S.C. 1182(e)) is amended—

(1) by striking out "whose (i)" and inserting in lieu thereof "(i) whose";

(2) by striking out "or" immediately before "(ii)";

(3) by inserting immediately before "shall be eligible" in the first sentence the following: "or (iii) who came to the United States or acquired such status in order to receive graduate medical education or training"; and

(4) by inserting ", except in the case of an alien described in clause (iii), immediately after "Provided further. That".

(d) Section 212 of such Act (8 U.S.C. 1182) is amended by inserting at the end thereof the following new subsection:

(j)(1) The additional requirements referred to in section 101(a)(15)(J) for an alien who is coming to the United States under a program under which he will receive graduate medical education or training are:

"(A) A school of medicine or of one of the other health professions, which is accredited by a body or bodies approved for the purpose by the Commissioner of Education, has agreed in writing to provide the graduate medical education or training under the program for which the alien is coming to the United States or to assume responsibility for arranging for the provision thereof by an appropriate public or nonprofit private institution or agency, except that, in the case of such an agreement by a school of medicine, any one or more of its affiliated hospitals which are to participate in the provision of the graduate medical education or training must join in the agreement;

8 USC 1101.

8 USC 1153.

Supra.

"(B) Before making such agreement, the accredited school has been satisfied that the alien has passed parts I and II of the National Board of Medical Examiners Examination (or an equivalent examination as determined by the Secretary of Health, Education, and Welfare), has competency in oral and written English, will be able to adapt to the educational and cultural environment in which he will be receiving his education or training, and has adequate prior education and training to participate satisfactorily in the program for which he is coming to the United States;

"(C) The alien has made a commitment to return to the country of his nationality or last residence upon completion of the education or training for which he is coming to the United States (including any extension of the duration thereof under subparagraph (D)), and the government of the country of his nationality or last residence has provided a written assurance, satisfactory to the Secretary of Health, Education, and Welfare, that upon such completion and return, he will be appointed to a position in which he will fully utilize the skills acquired in such education or training in the government of that country or in an educational or other appropriate institution or agency in that country; and

"(D) The duration of the alien's participation in the program for which he is coming to the United States is limited to not more than 2 years, except that such duration may be extended for one year at the request of the government of his nationality or last residence, if (i) such government provides a written assurance, satisfactory to the Secretary of Health, Education, and Welfare, that the alien will, at the end of such extension, be appointed to a position in which he will fully utilize the skills acquired in such education or training in the government of that country or in an educational or other appropriate institution or agency in that country, (ii) the accredited school providing or arranging for the provision of his education or training agrees in writing to such extension, and (iii) such extension is for the purpose of continuing the alien's education or training under the program for which he came to the United States.

"(2)(A) Except as provided in subparagraph (B), the requirements of subparagraphs (A) through (D) of paragraph (1) shall not apply between the effective date of this subsection and December 31, 1980, to any alien who seeks to come to the United States to participate in an accredited program of graduate medical education or training if there would be a substantial disruption in the health services provided in such program because such alien was not permitted, because of his failure to meet such requirements, to enter the United States to participate in such program.

"(B) In the administration of this subsection, the Attorney General shall take such action as may be necessary to ensure that the total number of aliens participating (at any time) in programs described in subparagraph (A) does not, because of the exemption provided by such subparagraph, exceed the total number of aliens participating in such programs on the effective date of this subsection."

(e) Section 101(a) of the Immigration and Nationality Act (8 U.S.C. 1101(a)) is amended by adding the following at the end thereof:

"(41) The term 'graduates of medical school' means aliens who have graduated from a medical school or who have qualified to practice medicine in a foreign state."

"Graduates of medical school."

HEALTH SYSTEMS AGENCIES

ISSUE

Should the recommendations of the Association on Section 1513(e) of P.L. 93-641, "Planning Agency Review of Proposed Uses of Federal Funds," be modified as a result of subsequent consideration of the impact of this legislation and of experience within the institutions during the past year?

BACKGROUND

At its April 1975 meeting, the Executive Council appointed a special task force to review the Health Planning and Resources Development Act of 1974, P.L. 93-641. The task force, chaired by Charles A. Sanders, M.D., General Director of Massachusetts General Hospital, was charged with responsibility for identifying the particular issues which require AAMC attention and providing guidance to AAMC staff. On May 22, 1975 the task force held its first meeting.

The following document was prepared by the task force in response to a request from HEW's Bureau of Health Resources Planning and Development. It represents the task force's comments on the interpretation of the section of the law pertaining to planning agency review of proposed uses of federal funds under Title IV (Research) and Title VII (Health Manpower Training). Due to the timeliness of the issue and the need for AAMC input to be received during the preliminary regulation development process, the paper was submitted on August 25, 1975 to Eugene Rubel, Director of the Bureau of Health Planning and Resources Development.

In summary, the Association recommended that:

- Program funds for undergraduate medical education under Title VII should be exempt from Agency review. Certain Title VII funds for graduate medical education that have as their central purpose to impact on the local health resources may appropriately be subject to a voluntary consultative review.
- Title IV research funds designated for the basic sciences and research projects with minimal service components should be exempt from Agency review.
- HEW may wish to encourage a voluntary consultative review between project recipients and Agencies for the limited number of Title IV research programs that have a significant "patient service component," e.g., large clinical projects, large cancer demonstration programs.

RECOMMENDATION

It is suggested that at the Annual Retreat the previous recommendations of the Association be reviewed for their appropriateness in the light of experience within individual institutions during the period subsequent to the adoption of those recommendations.

OPTIONS

1. Reaffirm the present recommendations.
2. Revise the recommendations so as to exempt support for graduate medical education.
3. Include in local review research programs which are primarily service in nature but with some research involvement, such as the cancer demonstration programs.

AGENCY REVIEW OF FEDERAL FUNDS UNDER TITLES IV AND VII

The purpose of this paper is to present the views of the Association of American Medical Colleges concerning the Health System Agency and Statewide Health Coordinating Council (SHCC) review of proposed uses of Federal funds under P.L. 93-641. It is authorized in the law that the Health Systems Agency is responsible for the review and approval or disapproval of certain proposed uses of Federal funds for health-related projects in their respective health service areas.

Section 1513(3)(1)(A) states that:

". . . each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds --

"(i) appropriated under this (Public Health Service) Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 for grants, contracts, or loans, or loan guarantees for the development, expansion, or support of health resources; or

"(ii) made available by the State in which the health service area is located from an allotment to the State under an Act referred to in clause (i) for grants or contracts for the development, expansion, or support of health resources."

In addition, there are specific exceptions from mandated HSA review and the following exemption is in Section 1513(e)(1)(B):

"A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under Title IV (National Institutes of Health), VII (Health Research and Teaching Facilities of Professional Health Personnel), or VIII (Nurse Training) of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services."

It can be assumed that the law provides that, with the exceptions noted directly above, most projects funded through the Public Health Service Act, the Community Health Centers Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, will require review and approval by the HSA. Certain projects, however, should be designated a priori as being exempt from review. The discussion in this paper relates, for the most part, to the programs funded through Title IV and Title VII, and provides the Association's recommendations on planning agency responsibility for review of these two titles.

Title IV - National Institutes of Health

Projects funded under Title IV of the Public Health Service Act should be considered separate from Title VII with regard to the agency review authority. Clearly the intent of Congress, as stated in the Senate Report, was to exempt from HSA review research in the basic biomedical or health care delivery areas.

The Association believes that Title IV biomedical and behavioral research programs were intended to be exempt from the agency's scope of review. These research efforts are not undertaken to provide health services to the general population nor are the programs providing an additional resource which has as its central purpose the delivery of health care. Any curative patient care outcome which results will occur as a byproduct of the research activity rather than its immediate purpose.

The Association also believes that research funds designated for the basic sciences and research projects with a minimal patient service component should be exempt from Agency review. Characteristically, these projects are supported to address national questions of scientific importance and opportunity. It would not be in the best interests of the HSA which is not equipped to make knowledgeable scientific determinations, to be burdened with these reviews.

Some NIH research programs may impact on the health delivery and health resources in a surrounding area. Neither the program intent nor program objectives, however, are to change the health status of the local community. Activities such as the larger clinical trials, the comprehensive or specialized cancer and heart centers, and large control demonstration and health education programs are examples of these programs. The extent of the "patient service component" is these projects may serve as a motivation for local HSAs to pursue a voluntary consultative review. As an alternative to mandatory review of NIH programs, it is recommended that HEW encourage a voluntary consultative review between the and HSA as a means to achieve coordination.

The exemption for review of NIH research programs under Title IV should be extended to include research authorized under other titles of the Public Health Service Act and under other legislation. The intent of Congress is to have "research" exempt regardless of the source of support. Examples of these research programs include sickle cell disease and Cooley's anemia (Title XI).

Another NIH program which should be excluded from Agency review is the biomedical communication program. One of the purposes of the communications network is to provide "technical assistance." These efforts to facilitate the development of biomedical information and communications to be used as national resources are funded under Title III authority. Because the purpose of these projects is to test the feasibility of new communication techniques, and not to be used as a major part of the area health resources, the biomedical communications program would best be kept exempt from review.

If the voluntary consultative review process is adopted, there are other factors which should not be included in any such reviews. The Association believes that an agency should not be responsible for judging and evaluating

a project's scientific value, technical quality or the availability of safeguards for protection of human subjects. These factors are more properly and effectively determined by the NIH funding authority. Neither the staff capabilities nor agency resources will permit the agencies to review for these factors. More importantly, these matters are already the subject of an experienced and well developed review process and consequently, additional reviews by an HSA would be redundant as well as in all probability ineffect. Similarly, issues of confidentiality for research protocols must be assured throughout the entire review process.

Title VII - Health Manpower Training

The Senate Report (No. 93-1285) on the planning legislation makes it clear that "Federal funds intended to support research, or the training of health professionals are exempt from the review requirements of the proposed legislation." The Report of the Senate Committee on Labor and Public Welfare further notes that "research in the basic biomedical or health care delivery areas, and the training of health care personnel have an impact beyond the geographic boundaries of a particular area, and, therefore, are not an appropriate subject for review by the local health planning agency."

Legislation for the Title VII manpower provisions expired last year and to date, Congress has not enacted new legislation. Therefore, comments on HSA review of applications for funding submitted under Title VII must be considered in light of this situation.

The Association believes that manpower capitation funds should be totally exempt from state and local agency review. Since the purpose of these grants is for the development of national manpower resources, it is not an appropriate item for a local Agency to review. Also recommended as exempt from review are student loans, student assistance and financial distress grants. These educational programs are not for the support of final professional training points but rather mid-points in the continuum of medical education. Therefore, it is recommended that Title VII funds which are designated for undergraduate medical education be exempt from review.

There are certain special project grants for graduate medical education such as primary care programs and family medicine training, traineeships and fellowships which have an identifiable goal to achieve within the local area and may have as their primary purpose to impact on the local health resources and affect the availability of area health services. Although there is a relationship between residency training and the physician manpower needs of an area, the substantial amount of migration renders any projections less than meaningful. It is therefore recommended that HEW refrain from mandating HSA review of these graduate medical education funds, recognizing that if these programs have as their central purpose to impact on the local health resources, they are more appropriately subject to HSA voluntary consultative review.

General Comments

The sequence of project submission and review as it applies to the Health Systems Agency and the Federal Program funding authority is of particular importance to the review process. Unless exempt, an applicant will need the approval of both the HSA and the Federal agency prior to a final award of grants of contracts. Prior to HSA approval, an applicant should secure Federal agency approval in a manner similar to the current procedures; the applicant would then be required to seek HSA approval. Each review, however, should be separate and distinct, based upon predetermined criterion.

It would be advisable to foster early involvement of the local Agency and the project recipient. To minimize an Agency's work load, however, it is suggested that the HSA not make a final determination until it receives the finding of the Federal funding agency. This would also serve to prevent an HSA from "approving" projects which have not received the funding authority's review for technical quality, scientific relevance and program conformity. One last final caveat should be noted. The competitiveness of the environment demands that all reviews be timely and that special consideration be given to an appeals process that does not hinder or inhibit an applicant from receiving a project award.

"Renewal" and "continuation" of a project made in the absence of a Federal funding agency review should similarly be exempt from HSA review. A significant change in a project's work scope and/or an on-going project which receives a full review by the Federal funding agency should be appropriately reviewed by the HSA. Any project which was previously held to be exempt from HSA review and approval, should continue as such unless there is a determination by the Federal funding agency that the scope or purpose of the study has been altered so as to place it in a project category subject to review.

The Association believes that the intent of Congress was to utilize an HSA to coordinate other Federal health programs. Therefore, to the extent that it is "administratively feasible" the HSA should use its authority to monitor and review Federal health activities in their health service area from Agencies other than that of DHEW. It is further recommended by the Association that the Veterans Administration be urged to participate in the planning and review approval process in those areas where a V.A. health facility exists.

OUTLOOK FOR THE 95TH CONGRESS

ISSUE

What issues subject to legislative action during the 95th Congress are of the most concern to the AAMC and its constituents? How should the Association respond to each of these issues?

BACKGROUND

During 1977, Congress will be considering a number of major pieces of legislation that are directly relevant to the interests of the AAMC. These include:

A. Expiring Legislation:

1. National Cancer Act of 1971
National Cancer Act Amendments of 1974
2. Health Research and Health Service Amendments of 1976
3. National Health Planning and Resources Act of 1974

B. Appropriations:

1. FY 1978 Labor-HEW Appropriations
2. Supplemental FY 1977 Appropriations, including funding of health manpower programs

C. Expected Legislation:

1. Clinical Laboratory Improvement Act
2. Medicare and Medicaid Administrative and Reimbursement Reform Act
3. Reimbursement of teaching physicians under Section 227 of the Social Security Amendments of 1972
4. Federal Advisory Committee Act
5. National Health Insurance
6. National Labor Relations Act coverage of housestaff
7. Health Manpower Amendments

DISCUSSION AND OPTIONS

Expiring Legislation

1. The National Cancer Act

In the past, the Association has consistently opposed the removal of the responsibility for biomedical and behavioral research programs

from the National Institutes of Health. In 1971 the AAMC stated during testimony before the Senate and House Subcommittees on Health its approval of the broad mandate originally granted to the NIH to conduct research into the causes and prevention of disease. During that testimony, Dr. Cooper expressed the Association's opposition to the provisions of the National Cancer Act which gave special autonomy to the Cancer Institute, disrupted the governance structure of the NIH, and compromised the authority of its Director. This past fall the Association objected (during debate on the Arthritis, Diabetes and Digestive Disease Amendments of 1976) to the establishment of organizations which subverted the normal governance of the NIH and duplicated some existing NIH functions.

- . Should the AAMC oppose the renewal of this legislation, and urge instead that the NCI revert to the status quo ante within the NIH?
- . Should the AAMC object on more limited grounds to the renewal of certain provisions of the legislation, e.g., the "budget bypass" provision?
- . On a more general note, how should the AAMC deal throughout the next two years with the tendency of the Congress to overspecify the detail of biomedical and behavioral research legislation, and to establish statutory advisory groups (e.g., Arthritis, Diabetes and Digestive Diseases) which overlap the functions of the existing National Advisory Councils?

2. The Health Research and Health Service Amendments of 1976

These amendments constitute an omnibus law, with several programs affected by the renewal legislation. The programs involved concern genetic diseases, the National Research Service Awards, and the National Heart, Lung, and Blood program.

- a. Genetic Diseases: The amendments established specific, line-item programs regarding sickle cell anemia, Cooley's anemia, Tay-Sachs disease, and a special program of research into genetic diseases.
 - . Should the AAMC oppose the earmarking of specific line-item programs for individual diseases in general and the renewal of these programs in particular?
 - . Alternatively, should the Association support such programs under general NIH authorities and regular appropriations with or without report language to indicate the interest of the Congress in the areas?
- b. The National Research Service Awards were originally established

under Section 301(d) of the Public Health Service Act, which authorized the Surgeon General to "Make grants-in-aid to universities, hospitals, laboratories, and other public or private institutions, and to individuals for...research or research training..." Basically the amendments broaden the authority for research training to include biomedical and behavioral research training programs of NIH, ADAMHA and other federal agencies, and research training at federal institutions such as VA hospitals.

- . Should the Association support the concept of research training as stipulated in the amendments or press for a return to the original authorities for the support of these awards?
- . Alternatively, should the Association urge the Congress to revise the program in the following ways:
 1. To restore open-ended authorizations?
 2. To specifically authorize both pre- and post-doctoral training grants and fellowships?
 3. To reassign responsibility for establishing manpower needs in the various disciplines, fields, and specialties from the National Academy of Science (an inappropriate delegation of governmental responsibility) to the National Institutes of Health?
 4. To modify the counter-productive payback provisions which presently serve to discourage talented individuals from entering research while at the same time forcing individuals with little research ability to continue to conduct pedestrian research solely to avoid the payback penalty?
 5. To reconstitute these provisions in a bill devoted exclusively to research training?
- c. The Heart, Lung, and Blood Program presents several opportunities.
 - . Should the AAMC support renewal of the current authorities?
 - . Oppose the renewal in favor of return to the previous authorities?
 - . Propose to the Congress that the basic elements of the new authorities be continued, but with the recision of certain undesirable provisions, such as the National Heart, Lung, and Blood Centers, time and dollar authorization ceilings, etc.?

3. The National Health Planning and Resources Act of 1974

This Act is clearly destined for renewal. In light of this reality, the best course of action for the Association would be to try for modification or repeal of those provisions of major concern to the constituency. Two questions seem paramount:

- . Should the AAMC urge the Congress to include a mandated membership requirement which would ensure representation from the academic medical centers?
- . Should the Health Systems Agencies be required to review and approve proposed uses of federal health funds as is mandated in Section 1513(e) of the planning law and is this an issue on which the AAMC should take a position? Research funds administered by the NIH are excluded unless they support the development of the area's health resources or the delivery of health services. A dispute has arisen between NIH and the planning bureau regarding which NIH-funded programs should be subject to review under this stipulation. One option is for the AAMC to join with the National Cancer Institute and the NIH in seeking a modification in the renewal legislation to exempt outright all research projects from HSA review.

Appropriations

1. Labor-HEW Appropriations

The Association has long been actively involved in the process by which funds are appropriated for the Department of Health, Education, and Welfare.

- . Should the AAMC maintain its current method of operation regarding the FY 1978 LABOR-HEW Appropriations bill; that is, should the AAMC continue to operate both independently and in conjunction with the Coalition for Health Funding?

2. Supplemental Appropriations

The Health Professions Educational Assistance Act did not become law until mid-October, 1976. The Congress, therefore, did not include funding for this law when it wrote and passed the FY 1977 Appropriations bill and instead passed a Continuing Resolution to maintain funding at the FY 1976 levels until a Supplemental Appropriations could be passed by the 95th Congress.

- . Should the Association actively lead the health professions in the attempt to gain full funding for FY 77 for this legislation?

Expected Legislation

1. The Clinical Laboratory Improvement Act

This Act failed to pass last session principally because time ran out on the 94th Congress. Designed primarily to set standards for the employees of clinical laboratories in order to halt the widespread fraud that exists in commercial laboratories and to assure the quality and reliability of clinical tests, the proposed bill mandates certain training requirements that are not relevant to clinical investigators. Furthermore, the bill does not adequately distinguish between those clinical laboratories that are involved solely in research, those that perform routine clinical measurement, and those that combine these two functions. The passage of this legislation, which appears to be likely during the first session of the 95th Congress, could, if not modified, impose hardships upon clinical investigators and greatly impede the progress of clinical research.

- . Should the AAMC continue to urge the Congress to provide exemptions from the training requirements for those clinical investigators involved totally or partially in research?

2. Medicare and Medicaid Administrative and Reimbursement Reform Act

In March of 1976, Senator Talmadge (D-Ga.), Chairman of the Health Subcommittee of the Senate Finance Committee, introduced the Medicare and Medicaid Administrative and Reimbursement Reform Act. As the major bill before the Congress intended to resolve many of the problems regarding the administration of these programs and the reimbursement process to providers, most particularly physicians and hospitals, this bill is of extreme concern to the members of the Council of Teaching Hospitals. The Association has worked with the Senate staff and testified previously on this bill.

- . Should the AAMC continue its current efforts to work closely with the Subcommittee staff on this bill?

3. Social Security Amendments of 1972

The AAMC succeeded in postponing the implementation of Section 227 of the Social Security Amendments of 1972, which concerns the Medicare reimbursement of teaching physicians. During the postponement, the Institute of Medicine studied the problems associated with Section 227 and issued its report to Congress. The Association has developed a detailed policy response to the IOM recommendations in this area, and has testified on the basis of that policy. The postponement of Section 227 will expire September 30, 1977 and modifying legislation is expected.

- . Is the Association's position in response to the IOM report a sufficient basis for the development of legislative strategy on Section 227?

4. Federal Advisory Committee Act

After several months of hearings and debates during 1976, the Congress passed the Government in the Sunshine Act, which became law on September 13th. The Act, designed to open up the decision-making processes of the federal agencies to the public, made significant changes in the Freedom of Information Act. Originally, this bill only amended the FOIA, but an amendment was added that applies these same revisions to the Federal Advisory Committee Act. This amendment placed the NIH/NIMH peer review of research grant applications under the provisions requiring all agency meetings to be open to the public. The exemptions that previously allowed the NIH/NIMH study sections to be closed to the public on the grounds that these meetings considered inter-agency and intra-agency memoranda were removed. Although these NIH/NIMH meetings will be able to be closed under other exemptions regarding invasion of privacy or implementation of proposed agency action, definitive legislation is necessary to protect the confidentiality of the peer review process. There have been indications of Congressional interest in modifying the law specifically to protect the peer review system.

- . Should the Association support such an amendment to the Federal Advisory Committee Act?

5. National Health Insurance

6. National Labor Relations Act Coverage of Housestaff

7. Health Manpower Amendments

Because these last three proposals are the subject of separate agenda items, no discussion is included here.

PERSONAL CHARACTERISTICS ASSESSMENT

ISSUE

Should the Association undertake a project to facilitate the assessment of the personal characteristics as they affect student performance in the clinical setting?

BACKGROUND

This issue continues to be a predominant concern of our faculties. Personal characteristics assessment first received formal attention in the Medical College Admissions Assessment Program (MCAAP) Task Force Report as a major evaluation need for the selection of students for admission. Developing techniques for personal characteristics assessment was endorsed by the Executive Council when it established a priority for the development of non-cognitive measures in admissions assessment nearly equal to that for the development of the New MCAT. Staff, in concert with a specially constituted working group, proposed a specific project to develop assessment instruments to the Executive Committee Retreat in 1975. Enthusiastic support was given to the plan and staff immediately began to explore all possible sources of outside support. We, unfortunately, were not able to secure the necessary support to make a serious beginning. Three foundations, the Kaiser Family Foundation, the Robert Wood Johnson Foundation, and the Kellogg Foundation all expressed serious interest in the activity. The first two offered to participate in funding of such an effort, but were unable to underwrite the entire amount (\$400,000 per year for four years) because of existing commitments. The Kellogg Foundation eventually declined after considering the proposal for four months, stating that the project did not have sufficiently direct relevance to the Foundation's priority of enhancing the quality of medical care.

These developments, other feedback from foundations, and continuing insistence from the membership that the AAMC respond to assessment needs in this area, resulted in the development of an alternate proposal. This proposal narrows the focus to the development of more explicit criteria for describing personal characteristics of students in the clinical educational setting. Strong impetus in this direction also derives from the recent intrusions of the courts into the areas of student evaluation, particularly in clinical settings, where the criteria faculty are utilizing to expel or to not promote a student are being challenged. It seems inevitable that more systematized and better documented evaluation mechanisms will be required in order to maintain our academic integrity.

ALTERNATE STRATEGY

The working group and staff have separated out from the comprehensive project discussed at the Retreat last year that component focusing on working with faculty to make more explicit the criteria they use to evaluate personal characteristics of medical students' clinical performance, and on developing more systematic and better ways of demonstrating these evaluations. The components to develop evaluation instruments to be used in admission selection have for the time been set aside. Improved assessment of students' personal characteristics will be an essential part of the validation of any future predictive instruments, both in this area and for the New MCAT. Concentration on this component has the added advantages of enhancing the evaluation of medical students in clinical settings. In addition to the needs for improved assessment stated above, there seems little doubt that admission to graduate programs will require increasingly specific and more comprehensive information about clinical performance as competition for available positions increases.

Instead of relying on testing organizations to implement this project, the available talent of our schools will be utilized. Preliminary discussions with several medical schools have identified individuals with the necessary expertise and willingness to become major participants in the project. Developing these relationships will provide resources to member institutions to assist in developing the criteria, and the direct involvement of several institutions should pave the way for greater acceptance and broader utilizations of the products derived from the project.

PROPOSAL FOR DISCUSSION

That the Association invest funds in this project (about \$50,000 in FY 1978) with the intent of producing a more systematic approach to the evaluation of the personal characteristics of students' performance in the clinical educational setting. Refinement of proposals for personal-characteristics-assessment instruments to be used for admissions selections will be pursued and outside funds will be sought on a project-by-project basis as they are developed.

RECRUITMENT OF FEDERAL HEALTH OFFICIALS

ISSUE

In what ways can the AAMC facilitate the recruitment and retention of highly competent individuals for mid and senior level positions in federal health agencies?

BACKGROUND

The increasing involvement of the federal government in programs directly or indirectly related to health activities together with the dependence of AAMC constituents on federal funding highlights the importance of highly competent individuals managing those programs. The difficulties of attracting well qualified persons for these types of positions have become more serious over the last decade. The causes are manifold and include the growing gap between income in the private sector versus that from government salaries, the decreased flexibility in program management consequent to the greater detail in authorizing legislation and operating regulations, the aftermath of the Nixon era impact on the career federal official, and the sheer complexity of the programs confronting the nation in the health area. These and other factors have resulted in the exacerbation of the always difficult problem of recruiting and retaining highly competent individuals, especially in professional categories, within government service.

As a primary element in the health area and as the largest single source of prospective employees for the federal government in health agencies, the constituency of the AAMC would seem to have a responsibility as well as a matter of enlightened self-interest to adopt whatever measures are feasible so as to facilitate the recruitment and retention process.

OPTIONS

The Association already directly or indirectly has undertaken efforts to assist federal officials in this area. The possibility for further assistance, therefore, involves in all probability a combination of enhanced efforts in some areas and consideration of new efforts in others.

Options include:

1. Greater emphasis on the need for more realistic salary scales for senior officials.
2. Enhanced use of the inter-governmental personnel authority for exchanges of individuals for limited periods of service.
3. Expanded utilization of opportunities during sabbatical periods for service by executives and faculty members in government agencies.

THE PROCESS OF DEVELOPING CCME POLICY

ISSUE

Can the CCME operate effectively and meet societal and professional expectations under its present modus operandi, which requires unanimity among five parent organizations on all policy issues and has assigned all staff functions to one of these five organizations?

BACKGROUND

Beginning in the mid sixties, a number of organizations perceived a need to extend the function discharged by the LCME to the domain of graduate medical education. A series of discussions culminated in a meeting held on January 25, 1972 from which emerged a five point proposal including: the establishment of a Liaison Committee on Graduate Medical Education (LCGME), with representation from each of five organizations (American Medical Association, Association of American Medical Colleges, American Hospital Association, American Board of Medical Specialists, Council of Medical Specialty Societies); the establishment of a Coordinating Council on Medical Education (CCME) as an umbrella organization over both the LCME and the LCGME. The proposal included the stipulation that the CCME would be responsible for developing policies with respect to both undergraduate and graduate medical education, for approving policies developed by the liaison committees, and for referring all approved policies to the parent organizations for ratification. The principle was firmly established that policy decisions were subject to approval by all parent organizations.

At its meeting on February 5, 1972, the Executive Council of the Association of American Medical Colleges approved the five point proposal in principle and on May 19, 1972 the specific proposal for the establishment of a Coordinating Council on Medical Education, which contained two important conditional assertions. Under the heading "Authority" this proposal stated "...For the time being, all policy matters must be approved by all parent professional organizations." Under Section 7, headed "Financing", the proposal contained a statement--"B. For the time being, the AMA shall provide staff and secretarial services for the CCME." On March 19, 1973 the CCME adopted a set of bylaws that were essentially consonant with all of the previous documents except that, unsurprisingly for a set of bylaws, the conditional elements with respect to unanimity of parent organizations on policy issues and the temporary nature of the AMA staff support were not included. More recently, a Liaison Committee on Continuing Medical Education (LCCME) has been organized under the CCME.

In many respects, the CCME has functioned effectively as a forum for discussion, as a reviewer of liaison committee policies and as a creative force in the development of new policy. It seems to have functioned best where it has had to function least, mainly in the arena of undergraduate

medical education. Here there is a long history of cooperation between the AAMC and the AMA; issues of concern for the other three organizations do not arise frequently and there is no staff domination by one organization. The LCME procedures and practices are now well established.

However, in the realm of graduate medical education and more recently in that of continuing medical education, it has been far more difficult for the CCME to achieve unanimity. Historically, the AMA, through its Residency Review Committees, had played the lead role in the accreditation of residency programs and the ABMS and CMSS have had a keen interest. Under the concept of medical education as a continuum, the medical schools have recently begun to see themselves as centrally concerned in both graduate and continuing medical education and thus having at least partial hegemony not only over housestaff training, but also over the educational experience of the practicing physician. The AHA, representing the hospitals in which graduate medical education takes place, also has a large stake in the associated problems.

An important parallel development has been the growing conviction on the part of public authorities, both state and federal, that some of the social problems of our times, the distribution of physicians by geographic area and by specialty, the protection of the consuming public from incompetent physicians, were related to the processes of graduate and continuing medical education and to government-mandated requirements for specialty certification and licensure. The past decade, and particularly the last several years, has seen a rapid growth in public expectations for some solution to these problems and in the interest of public officials in dictating them.

The nation has a long tradition under which the private sector has voluntarily managed, and submitted to, quality control processes in medical education. The LCME and the Joint Commission on the Accreditation of Hospitals (JCAH) are examples in which this process has been highly successful and essentially non-controversial. Success had depended on cooperation between interested parties and effectiveness has reflected a high consensus between organizations on the key problems and issues. For this reason, there has been little need on the part of public officials to do any more than ratify private sector decisions.

The present process for developing CCME policy has given rise to questions about the viability of this organization as presently constituted and operated. Substantial differences in outlook between the parent organizations has led to several impasses and actions have often been delayed or blocked by one or more of the parent organizations. In the absence of consensus and unanimity among the five parent organizations of the CCME, inaction and paralysis is a real possibility. If this should involve major issues in which the public or its representatives perceive a public or social interest, need or imperative, government may be tempted to preempt jurisdiction from the private sector.

OPTIONS

There are two major foci for discussion: the CCME requirement for unanimity (versus majority rule); and the AMA staffing of the CCME (versus an independent or a rotating staff).

A. Unanimity

Are the power relationships such that the five organizations comprising the CCME can never reach unanimity on the bulk of the important policy issues likely to arise over the next decade? If the answer to this is yes, the prognosis for the CCME is grim and it hardly warrants any further investment of AAMC effort.

Is it conceivable that any important new policy thrusts in medical education can emerge without essential consensus among the parent organizations? If the answer to this is no, then the AAMC ought to invest its best brains and most skilled and artful bargainers in negotiating the most favorable consensus. If the answer is yes, the AAMC could work to substitute majority rule for consensus or, alternatively to establish the most powerful ad hoc alliance possible on every issues, including, where necessary, taking unilateral action without allies when feasible.

B. Staffing

The total control of staff by the AMA has been a frequent source of frustration, and a number of alternatives have been suggested:

An independent staff has been proposed but never specifically defined. What would be the appointment process? What structure? To whom would it report? How can a staff report to 17 individuals divided into a number of conflicting blocs. How could CCME control over staff be guaranteed? How could it be financed? Where housed?

Rotation of staff responsibility, as with the LCME. Is this a feasible option? Could the ABMS and the CMSS handle the staff functions when their turns came up? Is the CCME agenda for action one that lends itself to rotating staff?

Independent staff plus a rotating secretariat, with staff reporting seriatim on an annually rotating basis to an individual in the parent organization which is responsible for the secretariat functions that year.

RENEWAL OF HEALTH MANPOWER LEGISLATION

ISSUE

How might the Association best prepare for the renewal of health manpower legislation in 1979?

BACKGROUND

While the ink is hardly dry on the President's signature of P.L. 94-484, the Health Professions Educational Assistance Act of 1976, it is not too early to think about the posture of this organization when the Act comes up for renewal. In the normal course of events, an Administration alert to the controversial character of health manpower legislation will probably provide for some lead time as will the traditional sponsors of the bill in both the House and Senate; therefore, the introduction of legislation in the spring of 1979 or 30 months hence, would be a reasonable expectation. Such legislation would have required initial discussion for drafting in the spring of 1978, some 18 months hence. The background of the current health manpower legislation is well known. Direct federal support for medical education, while long advocated, met with considerable resistance both within and without the Congress. The first Health Professions Educational Assistance Act was passed in 1964. This authorized limited functions, the construction of health educational facilities and loans to medical students. Two years later, P.L. 89-290 provided, for the first time, operating support to medical schools. The major significance of this statute was that a set of performance requirements was imposed upon the schools as a precondition for receipt of federal operating support. Subsequent renewals in 1968, 1971, and again in 1976 have continued the earlier basic pattern of support.

The options that ought to be considered for the next renewal of health manpower legislation are wide open at this time. The concept of basic operating support will certainly be questioned. Service-related student assistance will probably come under careful evaluation. The types of "strings" tied to these awards will certainly depend upon the needs perceived by members of Congress and the Executive Branch. The imminence of national health insurance, currently unpredictable, will also play a large role in influencing manpower policies.

QUESTION FOR DISCUSSION

Is it worthwhile for the Association to appoint a task force now to begin considering legislative specifications for the next renewal of health manpower legislation?

MAJOR PROGRAMS OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

A Brief Resume of AAMC Activities Organized by Department and Division
(More detail on programs and staff can be found in the 1975-76 Annual
Report)

DEPARTMENT OF ACADEMIC AFFAIRS

Office of the Director

Liaison Committee on Graduate Medical Education - Attend six two-day meetings per year of LCGME and serve on numerous subcommittees.

Education News - Five issues a year of AAMC Education News are prepared for mailing to 40,000 faculty.

CAS Brief - Quarterly, a two-page report of the status of various Legislative and policy issues is prepared for the 61 member societies of the CAS for re-circulation to their individual members.

Biomedical Research

Monitoring programs of the NIH, ADAMHA and other federal agencies which support biomedical/behavioral research and research training.

Representing the AAMC in special areas related to research (e.g., protection of human subjects, confidentiality of research protocols).

Conducting special studies of medical faculty, research training and biomedical research.

Serving as a principal office for communication with and staffing for the Council of Academic Societies.

Educational Measurement and Research

Biochemistry Special Achievement Test - An annually revised test administered to 1683 students at 20 participating schools for diagnostics as well as final examination applications.

Longitudinal Study-Class of 1960 - A follow-up of 7500 physicians from the class of 1960 in which the relationships among medical education, training experiences, and characteristics of current medical careers are examined in the light of major policy concerns.

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Medical College Admission Testing Program - A program involving the administration of the test, the distribution of score information, and the development and enforcement of associated policies under contract with the American College Testing Program.

Admissions Test Research and Development - The development of the New MCAT, its continued maintenance, and the conduct of research studies and information dissemination activities related to its appropriate use and interpretation.

Personal Qualities Assessment - A research and development effort designed to enhance the possibility of measuring those characteristics in the context of admissions and medical student evaluation.

Group on Medical Education (GME)- An attempt through an organization of medical educators to enhance information and resource sharing through regional and national efforts.

Research in Medical Education (RIME)- An annual conference held in conjunction with the Annual Meeting as a forum for the peer review and sharing of medical education research studies and programs.

Three Year Curriculum Project - A study concerning three year curricula in twenty-five U.S. medical schools in which curriculum characteristics, student progress data, student career choice patterns and program conversion information are being analyzed.

Faculty Development

In the midst of a survey of 2700 full-time medical school faculty, to determine characteristic teaching patterns, areas of difficulty, and interest in possible help with instructional improvement.

Planning a program of self-assessment of instructional strengths and problems to be offered for voluntary, confidential participation of all medical school faculty.

Conducted a "Workshop on Workshops" for 44 participants from 22 medical schools, at the AAMC Annual Meeting. More than twice that many applied. Will be offering this again.

Planning a pilot clearinghouse on educational reports and resources.

Student Programs

Organization of Student Representatives (OSR) - Staff OSR. Edit OSR-AAMC Bulletin Board, a quarterly newsletter published as an insert in STAR. Published the OSR Accreditation Handbook, a manual designed to assist students participating in LCME site visits of their medical schools.

Staff Group on Student Affairs (GSA) which includes admissions, financial aid and minority affairs officers, and registrars of U.S. medical schools. Update Student Affairs Bibliography. Edit the Student Affairs Reporter (STAR), a quarterly newsletter for GSA members, deans, and OSR representatives featuring information about admissions, financial aid, GSA meetings, and other student affairs-related items.

Develop programs related to the admission of medical students. Administer program assisting two year U.S. schools to transfer students to M.D.-granting institutions.

Develop programs related to helping schools utilize and administer existing and potential sources of financial aid. Staff Task Force on Student Financing to examine and develop existing and potential sources of assistance for medical students. Created guidelines for scholarship program for U.S. Olympic Committee.

Administer \$10-million Robert Wood Johnson Foundation Student Aid Program for medical students, including gathering and maintenance of longitudinal financial assistance data for approximately 15,000 female, minority, and rural students, and general coordination of this effort for 116 participating schools of medicine and osteopathic medicine. (Supported by \$10,000 annual administration grant from the Foundation.)

Investigation of apparent application irregularities (forged transcripts and letters of evaluation, falsified biographic information, etc.) according to policies and procedures approved by the AAMC Executive Council in 1973, including notification to legitimately interested medical schools of confirmed irregularities.

Assist schools through the GSA to counsel students especially regarding NIRMP and opportunities in graduate medical education.

Administer a special registration for Vietnamese refugee medical students to take NBME Part I.

Surveyed schools to determine that only about 70% have mal-practice insurance for students.

Offer Simulated Minority Admission Exercises to admission officers, advisors, and admission committees to help to enhance the assessment of minority applicants to medical school.

Publish "Minority Opportunities in U.S. Medical Schools," (MOUSMS) to provide information on special programs for minority recruitment and retention to prospective minority medical students.

Prepare and circulate the Medical Minority Applicant Registry (Med-MAR) to assist schools to identify disadvantaged candidates to medical school.

Staff AAMC Task Force on Minority Opportunities in Medicine.

Edit The Advisor, a periodic newsletter for undergraduate pre-medical advisors, featuring information about AAMC meetings and activities of interest to them and to medical school applicants.

Monitor commercial activities (test preparation courses, publications, placement services, etc.) targeted toward premedical students, including--when appropriate--communication with entrepreneurs.

Liaison with premedical advisors and their organizations, including meeting and workshop attendance, maintenance of advisor mailing list, and general correspondence.

Student Services

American Medical College Application Service (AMCAS) - A non-profit centralized application processing service for applicants to U.S. medical schools.

Coordinated Transfer Application System (COTRANS) - Assists U.S. medical schools by evaluating required credentials of U.S. citizen medical students seeking transfer from foreign medical schools to U.S. medical schools.

Advisor Information Service - Premedical advisors who subscribe to this service may receive information from AAMC about the success of applicants from their school.

Student Information Service - A referral service for information on specialized health careers and provides the prospective medical school applicant with an understanding of the practical procedures involved in the admission process.

Student Records - Maintains data on the current enrollment status of all students in U.S. medical schools.

BHM (funded projects) - Cooperates with other AAMC Divisions in providing data and processing material related to BHM studies -- particularly the Survey of How Medical Students Finance Their Education, and the Graduation Questionnaire.

Student Studies

The Division of Student Studies is currently conducting a number of major studies related to medical school applicants and students. These include recurring studies of applicants and enrollees and special studies of the admissions process, career choice, student financing, PHS/NHSC participants, and U.S. citizens studying medicine abroad. Much of the funding for these studies now comes from the Bureau of Health Manpower.

DEPARTMENT OF HEALTH SERVICES

Project for the Development of Curriculum for Physicians Training
in HMOs

This project has been completed and the Department is now in the process of preparing a monograph on this subject which will contain papers dealing with the following issues: curriculum design for ambulatory care experiences for both undergraduate and graduate medical students, implementation and evaluation of such curriculum design, and several proposed methodologies for calculating the educational costs involved.

Project for the Development of Models for the Provision of "One Class"
Ambulatory Care Services in University Affiliated Teaching Hospitals

The Department is conducting a series of workshops on the subject of outpatient department restructuring. This effort, aimed at facilitating improvement in the teaching hospitals' ambulatory care services and teaching components, will continue into 1977. An institutional guide on this subject will be produced by June 1977.

AAMC Survey of Primary Care Educational Programs: Progress Report

In 1973, the Department surveyed the 116 constituent academic medical centers to ascertain the state of educational programs in ambulatory care. These institutions were resurveyed with essentially the same instrument in 1976 and the Department is currently analyzing the latest data in order to document current trends in academic medical center primary care education.

DEPARTMENT OF INSTITUTIONAL DEVELOPMENT

Liaison Committee on Medical Education

AAMC provides the secretariat on alternate years which includes the scheduling, selection of team members and managing the writing and review of 40 to 50 accreditation reports per annum. Considerable consultation with schools preparing self-study is required.

Accreditation of New Schools

There are several pre-accreditation stages which require consultation and counselling primarily. Many initial inquiries and preliminary visits are required annually, but only a few new schools finally emerge. On the average, there are about a dozen in various stages of serious development at any one time.

Liaison with other Organizations Associated with Accreditation

The Council of Medical Education of the AMA, Office of Education, Council of Specialized Accrediting Agencies, Council of Post-secondary Accreditation, State Boards of Higher Education and Regents, Bureau of Health Manpower, other professional organizations with counterpart activities.

Council of Deans

Provides staffing for Council of Deans Administrative Board and meets with and facilitates meetings of regional sections of COD and the Deans of new and developing schools.

New and Visiting Deans Program

Prepares new deans package and arranges for orientation of new deans to programs of the AAMC and other agencies in Washington, D.C..

Council of Deans Spring Retreat

Each year the Council of Deans plans a full 3 day program around a major theme of primary importance to the Council which usually results in the preparation of a proceedings or several published papers.

Professors Emeriti Program

Under a grant from the National Fund for Medical Education, matches professors emeriti with medical schools needing assistance on an interim basis for periods of up to a year.

Management Advancement Program

Under a grant from the Robert Wood Johnson Foundation, the department conducts a program for developing the management skills of key academic medical center executives and decision-makers - deans, hospital directors and department chairmen. Faculty and consulting expertise is drawn from competent sources throughout the country. A formal evaluation of the program is being carried out.

Management Education Network

Under contract with the National Library of Medicine, access to management theory, information and practice is being made available to a much broader audience. The program has four principal activities: Management Literature Retrieval Center; the development/production of self instructional modules; selected management studies in 6 areas: academic medical center organization, academic review and evaluation, departmental restructuring, rewards in an academic system, management in a dispersed educational system, educational operations analysis; and simulation models as a management tool.

Institutional Studies

A variety of activities are initiated or underway primarily in response to specific needs expressed by the medical schools. Legal consultation and liaison has become a prominent aspect of this response as issues of significance appear to require litigation or have already reached the courts. Examples include, reverse discrimination, standards for promotion, affirmative action cases, confidentiality and privacy, ownership of patient records, LCME challenges, biomedical research problems. Attention to tenure and unionization, and the study of the role and career patterns of deans and vice presidents also continues. This year the department conducted a study of hospital/medical school affiliations under contract with the Bureau of Health Manpower.

DEPARTMENT OF PLANNING AND POLICY DEVELOPMENT

Office of the Director

The Department of Planning and Policy Development is made of a central office and two sub units, the Division of Operational Studies and the Division of Information Systems.

Governmental Relations

Congressional activity is monitored by daily review of the Congressional Record, attendance at Committee hearings and mark-up sessions and sessions of the full Congress. New bills introduced in Congress and other federal documents are analyzed and Association position papers, testimony, and other appropriate communications to the Congress and to Executive agencies are prepared. Assembly and Deans Memos and notes for the Weekly Activities Report are used to inform constituents of the status of legislation and other federal activities.

Coordinating Council on Medical Education (CCME)

AAMC participation in the activities of the CCME is coordinated and staffed through the Office of the Director of the Department of Planning and Policy Development

Division of Operational Studies

The Division of Operational Studies is organized into a Financial and Management Information Unit, and an Institutional and Faculty Information Unit. Activities of the Division are described briefly in the paragraphs below.

LCME Annual Medical School Questionnaire - Part I

Activities on this project include survey instrument design and periodical updates, workshops with the constituency to improve accuracy and comparability of data reporting and advice for survey revisions, data collection and verification, and liaison with the American Medical Association on financial information.

Group on Business Affairs

The Division provides staffing for the GBA. Staff responsibilities include organization of regional and annual meetings, publication of an annual directory, distribution of information materials and clerical and professional staff support to the Steering Committee.

Planning Coordinators' Group

Support for the Planning Coordinators' Group includes organization of regional and annual meetings, publication of an annual directory, distribution of information materials, and professional and clerical support to the Steering Committee.

Faculty Salary Survey

The Faculty Salary Survey is conducted annually with advice from a number of individuals in the medical schools responsible for reporting the data and utilizing the reports. Activities include instrument design and revision, data collection and verification, and reporting.

Cost Studies

The Association has been involved with program cost studies since 1967. At present, activity is limited to the distribution of materials, consultation with people at the medical schools and appropriate state and federal agencies, and review of methodologies utilized by the schools and by outside organizations.

Datagrams

The Division coordinates the publication schedules for datagrams, editing each one and reviewing the material presented for policy implications. Final copy is delivered to the Division of Publications for final edit.

Non-AAMC Questionnaires

The Division maintains a collection of non-AAMC questionnaires and is responsible for liaison with the Office of Management and Budget and federal data collection agencies in an attempt to facilitate information transfers relating to medical education. The principle aims are to reduce unnecessary data collection and to review definitions and forms to assist in meaningful reporting.

Data on Ambulatory Care Facilities

A data collection instrument has been designed and distributed to collect information on present and needed facilities for ambulatory care education in medical schools. Studies of these data will continue.

Issues, Policies and Programs

The Division has the job of maintaining the "Greenbook" entitled Issues, Policies, and Programs which provides a one-page description of the Association's position on various issues. The Division coordinates the preparation and review of these materials by the entire executive staff, edits the materials for consistency and supervises printing and distribution.

Faculty and Institutional Profiles

The Faculty and Institutional Profiles constitute a very substantial data base on medical schools and medical school faculties, which are utilized for routine reports, analytical studies and responses to ad hoc

queries from persons in the medical schools and in state and federal agencies.

Annual Ranking Reports

The Annual Ranking Reports provide comparable data on a large number of variables, including derived variables for each medical school. These reports place the schools in a regional and national perspective, to assist them in identifying strengths and problem areas in their own institutions.

Manpower Analyses

The Division prepares data for annual reports on the participation of women and minorities on medical school faculties and studies the career development process for faculty members to identify potential future problems. An annual report of medical school faculties is also prepared.

Division of Information Systems

The Division of Information Systems has no external programs of its own, but provides computer systems support for all of the activities of the Association. This includes systems analysis, programming, data entry, and computer operation.

DEPARTMENT OF TEACHING HOSPITALS

Legislation

The Department continually monitors the development and legislative history of Congressional bills and resolutions of concern to hospitals. The Department takes primary responsibility for Congressional staff liaison, legislative analysis, and testimony preparation on the subjects of hospital reimbursement, conditions of participation in federal medical care programs, health planning, and labor relations. In other topical areas affecting hospitals, the Department works cooperatively with other AAMC Departments to support their efforts.

Regulation

The Federal Register is reviewed on a daily basis for regulations, proposed rules and notices of interest to hospitals. As appropriate, the Department prepares comments on final and proposed regulations which are deficient from the perspective of COTH hospitals. Copies of significant proposed or final regulations are mailed to COTH members. When final regulations constitute an immediate and irreparable harm to COTH members, the Department works with other Association staff to prepare a court challenge of the regulations.

Executive Agencies

The Department establishes and maintains close relationships with executive agency personnel directing programs of concern to hospitals. These relationships are used to provide federal officials with an awareness of the teaching hospital impact of potential agency regulations. They are also used to call agency attention to the adverse impacts of promulgated regulations on teaching hospitals. To document such adverse impacts, the Department conducts single-purpose, special surveys of COTH member experiences.

Regulatory Agencies

The Department works cooperatively with COTH members having precedent-setting cases before federal regulatory agencies. Such assistance may include identification and contact of other interested parties, assistance with the institution's presentation, or the preparation and filing of an amicus curiae brief.

Executive Education

The Department works cooperatively with the Department of Institutional Development to establish and sponsor Management Advancement Program seminars for COTH chief executive officers.

Publications

The COTH Report, an eight page digest of current news and issues with a circulation of 2300 copies, is prepared monthly and distributed to AAMC constituents, members of Congress, and individual subscribers.

The COTH Directory of Educational Programs and Services is prepared annually. It provides operating, expense, residency, and educational program data on COTH members.

Surveys and Studies

A program of teaching hospital surveys combines four regular and recurring surveys with a limited number of special, issue-oriented surveys. The regular surveys are the Educational Programs and Services Survey, the House Staff Policy Survey, the Income and Expense Survey for University-Owned Hospitals, and the Executive Salary Survey. Two special surveys were conducted this year: the Survey of the Impact of Section 223 and the Survey of Professional Liability Insurance in University-Owned Hospitals.

DIVISION OF EDUCATIONAL RESOURCES AND PROGRAMS

Educational Materials Project

Information System--to develop and carry out, under contract with NLM procedures for appraising and selecting non-text educational materials for citation in AVLINE. AVLINE, a sub-system of MEDLINE, provides the academic health professions community with a computerized remotely searchable information system on education resource materials (audio, visual and computer based).

Continuing Medical Education

with guidance from the Ad Hoc Committee on Continuing Medical Education to formulate principles and policies in continuing medical education for promulgation through the AAMC's representation on the Liaison Committee on Continuing Medical Education or the AAMC constituency, and to provide initiative for R & D projects in continuing medical education.

International Medical Education

under contract with the Fogarty International Center to develop a self-instructional course as an introduction to international health (Principles of a Cross-Cultural and Comparative Approach to Health Problems) for elective use by students in medical schools and other health professional schools.

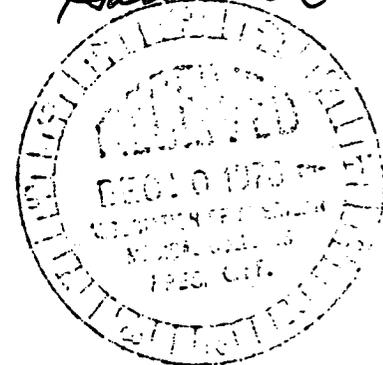
Social Security Institutions and Medical Education in Latin America

in collaboration with the Pan American Federation of Associations of Medical Schools to foster the principle of partnership between medical schools and the health services of the social security institutions in Latin American countries through programmed activities including workshops, conferences and local visits.

Jan 12 1977 CFS Adon
Association of Professors of Medicine Bd
Handout

SOL SHEPBY, M.D.
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December 7, 1976



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

Dear John:

The Council of the Association of Professors of Medicine on September 21, 1976, approved the following statement:

"The Council wishes to explore the possibility of enhancing the APM's effectiveness on broad national issues in health care, education, and research by creating a greater interaction with the Association of American Medical Colleges, possibly including an APM desk at AAMC headquarters".

We wish to thank you and your colleagues at the AAMC, John Sherman, Gus Swanson, and Tom Morgan, for joining the Council at our meeting in San Francisco on Sunday, November 14. The following statement from my minutes of the Council meeting of that date summarizes the essence, I believe, of our discussions:

"Substantial encouragement was received from President Cooper. He indicated that the purposes of both organizations are closely related and that each organization's self-interest could be enhanced by a greater interaction. Dr. Cooper indicated that AAMC policy on broad national issues is derived from the viewpoints of its constituents and that a close relationship with the APM would be another step in consolidating faculty around certain issues and would strengthen the AAMC policy-making process by bringing an important faculty closer to the AAMC. The Councilors of the APM were enthusiastic about the potential for enhancing our effectiveness on broad national issues and on issues which center about medical education.

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December 7, 1976

It was suggested that an APM office might be established at the AAMC headquarters, that it might be staffed by a senior AAMC officer on a part-time basis, with a secretary and other staff appointed as appropriate to its functions. The APM would share the indirect costs of the office. There was a general expression from both sides that the senior staff person might best be someone already on the AAMC staff.

It was decided that the Secretary-Treasurer of the APM would prepare a brief description of the functions of the proposed APM office. This would then be circulated to the Council for criticism and modification. It then would be sent to John Cooper so that he may have it for discussion at the AAMC Officers' Retreat which is scheduled for December 15-17, 1976."

The next day, Monday, November 15, 1976, this matter was discussed thoroughly at the APM Plenary Session with 56 APM members in attendance. Very substantial and enthusiastic support was expressed from the floor. No dissension was expressed. Therefore, we wish to proceed further with you to explore a possible relationship between the APM and the AAMC.

We envision that one of the present senior staff officers of the AAMC might assume a part-time function as an executive of the APM. An office within the AAMC headquarters in Washington would be established for this purpose. It would be staffed by a secretary, etc. The APM would support the function financially at an appropriate level.

The proposed arrangement could give the APM an awareness of important issues which we do not have presently. It could give the AAMC a directness in its' relationships with a large constituency which could further improve the AAMC's effectiveness.

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December 7, 1976

The APM office might assume some functions contemplated by the APM not yet implemented, such as:

- Publishing a roster of available fellowship positions
- Updating and maintaining on a current basis the data derived from our current Manpower Study.

The new APM office at the AAMC headquarters might be well-suited to bring the Chairpersons of Medicine into closer working apposition with the AAMC on important issues related to medical education in all its dimensions such as:

- Undergraduate medical education
- Graduate medical education
- Subspecialty fellowship program accreditation
- Licensure and re-accreditation
- Health Manpower Needs
- Faculty development
- Research training
- Research support
- National health insurance
- Third party reimbursement of teaching physicians
- Cost of medical care
- Government/medical school interrelationships
- Federal legislation, and regulation

The functions now carried out in the office of the Secretary-Treasurer should be the subject of further discussion.

The above may represent only a partial list. The concepts of our interaction as expressed above may need modification. Nonetheless, the general concept of close interaction, with a joining of our intellectual and other resources on specific issues affecting Internal Medicine and medical education represent the core of the intent.

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-4-

December 7, 1976

Please give me a call if we can be of help in filling in some of the details.
We await your response.

Best personal regards,

al

Alvin R. Tarlov, M.D.
Secretary-Treasurer

ART/ih

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Jan 12 1977
CFS Adm Bd Handout

association of american
medical colleges

January 5, 1976

MEMORANDUM

TO: FOR THE RECORD

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

SUBJECT: Planning for Joint Council Programs for the 1977 AAMC
Annual Meeting

In a meeting on December 27, M. Wilson, R. Knapp, J. Keyes, J. Hudson, and A. Swanson developed the following ideas for a joint Council program at the 1977 Annual Meeting. These ideas are to be discussed with the Administrative Boards of each Council at the January meeting.

Introduction

The 1977 Annual Meeting, with its theme on Graduate Medical Education, is being planned on the assumption that it is now obvious that the academic medical centers indeed have responsibility for graduate medical education. The tenor of the meeting will be that with the academic medical centers now having responsibility, it is important that the issues facing graduate medical education be enunciated and solutions sought.

Proposed Meeting Schedule and Format

Jointly sponsored meetings by the CAS, COD, and COTH will be held on Tuesday afternoon and Wednesday morning. The format will be two sessions for each meeting, divided by a coffee break, with three to four speakers briefly presenting their views or experience relevant to the assigned topics followed by discussion between speakers and from the floor.

There was a consensus that we should deal with practical problems rather than global generalizations.

Topic 1: The Interface Between Undergraduate and Graduate Medical Education

This topic would particularly focus on the issues surrounding the broad first year and the preparation of graduate medical students for ultimate differentiation into the several specialties. The possibility of Bill Hamilton, Chairman of Anesthesiology at UCSF, who is chairing the LCGME/CCME committee on the interface between undergraduate and graduate medical education, being a speaker was mentioned. No other speakers were suggested.

Topic 2: The Quality of Education - Quality of Life

The second session on Tuesday afternoon would focus on the balance between graduate medical education as an educational experience of high quality, and graduate medical education as an experience in learning through service. It was agreed that one or two house officers should be selected to speak to this subject as well as, as yet unidentified, faculty or graduate program administrators.

Topic 3: Does Financing Determine a Program or Does Program Determine Financing?

This would be presented on Wednesday morning as the first session and would explore the problems which current methods of financing present to graduate medical education. A potential speaker mentioned was Al Tarlov.

Topic 4: Institutional Responsibility

It is conceived that after the three previous topics have been thoroughly explored, potential approaches to solving these problems through greater institutional responsibility for graduate medical education would be set forth. No particular speakers were mentioned.

Brochure

There was considerable enthusiasm for the idea of developing a small booklet to be sent to CAS, COD, and COTH members and to selected other key individuals, such as certifying board presidents and secretaries and RRC chairmen. The booklet would set forth the basic problems facing graduate medical education and describe the two-session program.

There was agreement that if the program develops as hoped, transcription through a stenotypist may be desirable in order to publish the proceedings.

There was a brief discussion of the Task Force on Graduate Medical Education. Its precise role in developing the proposed program was not laid out. It is assumed that as the Task Force evolves, it may become a resource for identification of speakers and subtopics for the topics set out above. There was a consensus that the Task Force appointments should be delayed until after thorough discussion with the Administrative Boards of each of the three Councils.

cc: CAS, COD, and COTH Administrative Boards