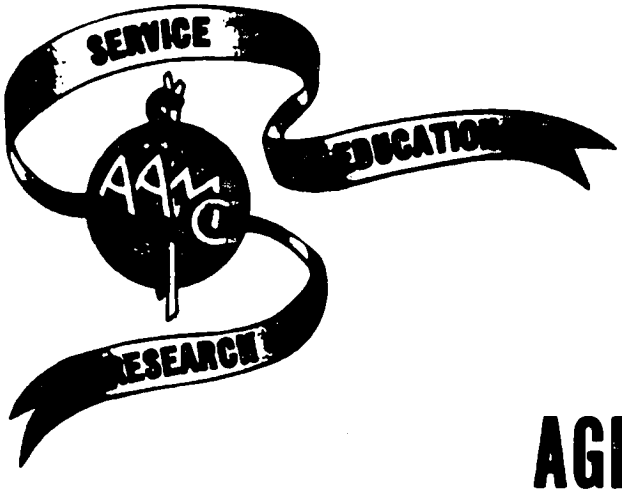

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Friday, November 3, 1972

1:30 pm - 5:00 pm

Pasteur Room
Fontainebleau Hotel
Miami Beach, Florida

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
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MINUTES

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

February 4, 1972

Palmer House Hotel
Chicago, Illinois

I. Roll Call

Dr. William B. Weil, CAS Secretary, called the roll. Thirty-six persons represented 33 of the 47 constituent societies. Member societies which were not represented were:

American Academy of Allergy
American Association of Chairmen of Departments of Psychiatry
American Association of Neuropathologists
American College of Surgeons
American Neurological Association
Association for Academic Surgery
Association for Medical School Pharmacology
Association of Pathology Chairmen, Inc.
Association of Teachers of Preventive Medicine
Association of University Professors of Neurology
Society of Academic Anesthesia Chairmen, Inc.
Society for Pediatric Research
Society of Surgical Chairmen
Society of University Surgeons

II. Approval of Minutes

The minutes of the meeting held October 29, 1971 were approved as circulated.

III. Chairman's Report

The Chairman reported briefly on several items of interest which are described in greater detail later in these minutes:

The AAMC Executive Committee Retreat was held in early December, 1971, during which the matter of institutional faculty representation in the AAMC was

explored in depth. The recommendation for establishment of an Organization of Faculty Representatives, analogous to the Organization of Student Representatives, and related to the Council of Deans, was brought before the Executive Council in its meeting later in December.

Dr. John A. Gronvall, Chairman of the AAMC Task Force on the Cost of Medical Education, appeared before the CAS Administrative Board on February 3, 1972, to bring to the Council's attention the national focus on the arrangements that clinical faculty may have with institutions whereby they are using such facilities for the generation of private income. Dr. Clark is appointing a Committee to explore this complex issue and to suggest ways in which the Council of Academic Societies might generate data that would be useful, keeping in mind the need for any data to be reflected against individual institutional costs and the need for data that would suggest some true measure of the time contributed by voluntary clinical faculty to the medical education enterprise.

IV. Membership Application

ACTION: Upon motion, duly seconded, the CAS Membership voted unanimously to recommend to the AAMC Executive Council the application of the American Association for the Study of Liver Diseases in the Council of Academic Societies.

V. Policy Statement of Eliminating the Freestanding Internship

The Council of Academic Societies considered the following policy statement:

> The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the

design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training.

Examples of free-standing internships would include:

(a) an internship offered in a hospital that has no residency programs and that has no relationship to other hospitals for graduate training;

(b) an internship offered in a hospital that has approved residencies, but that offers the internship as a discrete experience with no indication that it is coordinated with residencies in the same hospital or elsewhere.

ACTION: A motion was made and duly seconded to affirm the proposed policy statement of eliminating the freestanding internship. The original motion was subsequently amended, and duly seconded, to affirm the statement through sentence one and including the first clause of sentence two. The amended statement follows:

> The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the free-standing internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education.

The amended statement was affirmed with two dissenting votes.

VI. Recommendation for the Establishment of an Organization of Faculty Representatives

Dr. Clark traced the evolution of faculty representation in the AAMC from the original Coggeshall Report recommendation for faculty representation from both institutions and from academic societies to the Retreat Proposal for

the Organization of Faculty Representatives (OFR). In the CAS October 29, 1971 meeting a motion "supporting the development of a Council of Faculty within the AAMC" had been tabled because of the scheduled December Retreat of the AAMC Executive Committee. In its deliberations on February 3, 1972 the CAS Administrative Board could not reach a consensus on this item, although it was stated that the proposal for development of the OFR seemed the most viable at this point in time.

ACTION: Motion was made and duly seconded that the "Guidelines for the Organization of Faculty Representatives" on pp. 20-22 in the Agenda book (i.e. that emanating from the AAMC December 1971 Executive Committee Retreat) be approved.

Ensuing discussion primarily opposed the OFR as untenable to the faculty, who might (one said) choose to organize outside the AAMC if no more than token representation would be acceptable to the Deans.

SUBSTITUTE MOTION: The following substitute motion, duly seconded, was offered:

The CAS believes it is imperative to establish a Council of Faculties with the selection of two individuals from each institution, with the interim establishment of an Organization of Faculty Representatives.

(NOTE: This substitute motion was later withdrawn.)

Objections were raised to this compromise motion as an insult.

ACTION: A motion was made and seconded to take the October 29, 1971 motion "supporting the development of a Council of Faculty within the AAMC" off the table. By majority voice vote the motion supporting the development of a Council of Faculty within the AAMC was carried.

The substitute motion was then withdrawn.

ACTION: The vote was then taken on the original motion to establish an Organization of Faculty Representatives. This motion was defeated.

ACTION: A motion was then made and duly seconded to establish a Council of Faculties within the AAMC. This motion passed by a majority voice vote.

NOTE: Underscore added to indicate that this motion differs from the October 29, 1971 motion in being stronger, i.e. the earlier motion passed was "supporting the development of a Council of Faculty..." the latter "to establish a Council of Faculties."

VII. Federal Activities

Dr. John A.D. Cooper reported on current federal activities and developments of the Coalition for Health Funding. The CAS Membership are kept informed of all major AAMC activities by the AAMC President's "Weekly Activities Report."

ACTION: On motion, duly seconded, the following resolution was unanimously adopted:

Be it resolved that the CAS via the AAMC and the Coalition for Health Funding express our concern for the proposed decrease in support of the competitive research grant programs for the N.I.H. as contained in the proposed budget for 1973.

VIII. Liaison Committee on Graduate Medical Education

Dr. Clark next reported on points of agreement reached by Representatives of the American Medical Association, Association of American Medical Colleges, American Board of Medical Specialties, Council of Medical Specialty Societies, and American Hospital Association, at a meeting held on January 25, 1972 in Washington, D.C.

1. As soon as possible, there will be established a Liaison Committee on Graduate Medical Education, with representation from each of the five organizations, to serve as the official accrediting body for graduate medical education.

2. Simultaneously, there will be established a Coordinating Council on Medical Education to consider policy matters for both undergraduate and graduate medical education, for referral to the parent organizations.

3. The existing Liaison Committee on Medical Education and the new Liaison Committee on Graduate Medical Education will have the authority to make decisions on accreditation in their respective areas within the limits of policies established by the parent organizations and with the understanding that Residency Review Committees will continue to function.

4. All policy decisions will continue to be subject to approval by the parent organizations.

5. Policy recommendations may originate from any of the parent organizations or from the two liaison committees but will be subject to review by the Coordinating Council before final action is taken by the parent organizations.

IX. Workshop Proposal

A straw vote of the CAS membership indicated the majority favored mounting a "workshop on individualizing medical student curricula." Extramural support will be sought.

X. Dues Increase

Current annual dues per member society in the CAS are $100.00 Annual income generated to support CAS activities for the 47 member societies is, therefore, $4,700.00. There seemed to be a consensus on the need for an increase

in dues. No dues increase could be effected through the AAMC legislative process until 1973.

A direct capitation formula, to which the Membership had reacted previously, would, it was felt, impose inequitable financial requirements on the larger organizations without concomitant representation, i.e. each society, regardless of size, is entitled to two votes in the Council.

ACTION: The Administrative Board received as a mandate from the CAS membership the development of specific plans for restructuring and increasing dues in the CAS.

XI. Communications

Member societies need to be better informed on activities of the AAMC and CAS. It is, therefore, important that representatives communicate with the organizations they represent more often than their regular annual reports. Representatives now receive on a regular basis the AAMC President's "Weekly Activities Report."

Members of the Administrative Board are available to attend meetings of constituent societies and to acquaint their memberships with current and on-going activities of the AAMC and the CAS. Presentations that have been made to several societies have been well received as highly informative.

XII. Information Items

1. The matter of "Junior Clerkships" presented in the agenda was discussed.
2. The Primary Care Study Committee held its first meeting in January. This committee is charged to study the role,

obligations, and responsibility of the educational process in solving the public's expectation for primary care.

The Committee on Educational Technology for Medicine: Academic Institutions and Program Management (Eugene A. Stead, Chairman) is structuring its report around three primary areas:

1. Intramural organization of medical schools for education;
2. Inter-School organization for sharing of Educational Resources; and
3. Organization of Learning Resources to be Shared (Including Production, Distribution, and Evaluation; Author Recognition; and Copyright.

In addition, the National Library of Medicine has approached the Council of Academic Societies with respect to an inventory of existing, non-print media available in institutions and in academic societies and with respect to developing a roster of experts for evaluation of such materials.

Dr. James Erdmann, Director of the AAMC Division of Educational Measurement and Research, spoke on the future plans for the Medical College Admission Test (MCAT) and solicited CAS participation in its future development.

XIII. New Business

ACTION: On motion, duly seconded, the CAS voted unanimously to forward the following resolution to the AAMC Resolutions Committee:

> The Association of Chairmen of Departments of Physiology recognizes that significant contributions to the medical education process can be made by the early exposure of students to problems of human biology in non-medical school settings, and encourages the further exploration of these potentialities.

The Association, nevertheless, is convinced that physiology and the related basic medical sciences play an essential role in clinical medicine which cannot be sustained if formal responsibility for education in these areas is removed from the medical environment. We believe that there are aspects of physiology and other basic medical sciences whose relevance to the education of undergraduate and graduate medical students cannot continue to be made evident without constant interchange with other colleagues within the environment of a medical center.

We therefore resolve that the Council of Academic Societies be requested to endorse the concept that schools of medicine continue to include departments of the basic medical sciences to insure adequate representation of these disciplines.

We further resolve that this resolution be communicated to the several societies representative of basic science disciplines in the Council of Academic Societies with the hope that similar resolutions will be adopted by them.

NOTE: The resolution was not accepted by the AAMC Resolution Committee for presentation to the AAMC Assembly due to a lack of data on which the resolution had been based.

XIV. Adjournment

The meeting stood adjourned at 4:45 p.m.

MHL:cw
2/10/72

III. Chairman's Report

1. Policy Statement on the Protection of Human Subjects.

The Association and its constituents have always been concerned regarding their responsibilities for ensuring that the rights of human subjects used in biomedical investigations be protected. Recently, several events have focused attention on this responsibility. At the Executive Council meeting of September 15th, the following policy statement was adopted:

The Association of American Medical Colleges asserts that academic medical centers have the responsibility for ensuring that all biomedical investigations conducted under their sponsorship involving human subjects are moral, ethical and legal. The centers must have rigorous and effective procedures for reviewing prospectively all investigations involving human subjects based on the DHEW Guidelines for the Protection of Human Subjects as amended December 1, 1971. Those faculty members charged with this responsibility should be assisted by lay individuals with special concern for these matters. Ensuring respect for human rights and dignity is integral to the educational responsibility of the institutions and their faculties.

2. Policy Statement on Eliminating the Freestanding Internship.

The Executive Council approved this statement on May 19, 1972. It puts the Association on record regarding eliminating first-year graduate training programs which are isolated from involvement with advanced students.

The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal graduate training.*

**The freestanding internship is herein defined as an internship program in a hospital which has no residency training programs.*

3. Policy Statement on the Physician Draft.

With current Selective Service regulations due to expire in July 1973, the Executive Council believed it essential that a policy be adopted related to the continued drafting of physicians.

1. The "doctor draft" should terminate on July 1, 1973, the same date on which draft legislation expires. The termination of the doctor draft should apply to all individuals in college, medical school, or postgraduate medical training, regardless of age, selective service status or previous deferment. However, firm commitments previously made to specific services and programs by individuals should be honored.

(a) Subsequent to this termination date, military physician manpower requirements should be met entirely by volunteers. Current programs which include scholarships for medical students planning military service, higher pay scales for service physicians, the increased use of health professionals other than physicians, and the continuing critical review of the numbers of military physicians should be further developed and expanded. Retention of physicians in the service should be improved by changing current assignment requirements for those in higher rank, and by generally improving pay scales, working conditions, and opportunities for professional advancement.

2. If a physician draft call is necessary prior to the July 1, 1973 termination date, the vulnerability to military conscription should be determined by a random sequence number drawn by Selective Service specifically for this purpose. This proposed lottery system should be administered nationally rather than by local or state draft quotas. If a national administration is not possible, a national ceiling number should be set beyond which no physician could be called by any local board.

(a) Draft liability under the existing law should be limited to one year, with the individual to be vulnerable no earlier than two years after receipt of the M.D. degree.

4. Policy Statement on the Establishment of a Cabinet-Level Department of Health.

This statement, passed on May 19, 1972, is based upon the firm belief that the Department of Health, Education and Welfare has become unmanageable and that health is an area of sufficient concern to merit a separate Department.

Be It Resolved that the Association of American Medical Colleges wholeheartedly supports the establishment of a Cabinet-

level Department of Health to serve as the single point of responsibility for defining health policy, administering federal health programs and evaluating the state of the nation's health. The Department should be administered by a Secretary of Health appointed by the President with the advice and consent of the Senate. The Secretary should be responsible for all health programs now administered by the Secretary of Health, Education and Welfare including Medicare and Medicaid and any new program of national health insurance. In connection with establishment of a new Department of Health, an independent panel of experts should conduct a study to develop a thoughtful and coordinated national health policy and a detailed national health program for meeting current and future health needs for the United States.

5. Report of the Ad Hoc Committee to consider medical school admissions problems.

The Council of Deans requested that a task force be appointed to review the problems related to medical school admissions and make recommendations regarding the improvement of medical school admission procedures and policies. The report of that task force is on page 13.

IV. Action Items:

1. CAS Dues Increase

In mid-September all CAS representatives and officers of member societies received CAS Brief No. 10 describing the dues increase schedule recommended by the Administrative Board. The schedule is as follows:

Active Membership	# of Soc.	Annual Dues	Yield
Less than 300	28	$ 500	$14,000
300; less than 1,000	10	1,000	10,000
1,000; less than 5,000	8	2,000	16,000
5,000 or more	5	3,000	15,000
TOTALS	51		$55,000

2. Resolution on the Interaction of Basic and Clinical Sciences.

At its meeting on February 4, 1972, the Council of Academic Societies acted upon a resolution introduced by Dr.

(Continued on Page 19)

IV. REPORT OF THE AD HOC COMMITTEE TO CONSIDER MEDICAL SCHOOL ADMISSIONS PROBLEMS

Report of the Committee Convened by the Chairman of the Council of Deans to Consider Medical School Admissions Problems

July 11, 1972

Martin S. Begun
Associate Dean (Administrative)
New York University School of Medicine

Carleton Chapman, M.D.
Chairman, Council of Deans
Dean and Vice President
Dartmouth Medical School

John E. Chapman, M.D.
Associate Dean for Education
Vanderbilt University School of Medicine

Sam L. Clark, Jr., M.D.
Chairman, Council of Academic Societies
Chairman of Anatomy
University of Massachusetts Medical School

Clifford Grulee, Jr., M.D.
Dean, University of Cincinnati College of Medicine

Frederick Hofmann Ph.D.
Associate Dean for Admissions
Columbia University College of Physicians and Surgeons

Cheves McC. Smythe, M.D.
Dean, University of Texas at Houston, Medical School

Robert L. Tuttle, M.D.
Chairman, Group on Student Affairs
Associate Dean for Academic Affairs
University of Texas at Houston, Medical School

Harold Wiggers, Ph.D.
Dean, Albany Medical College of Union University

James Erdmann, Ph.D.
Director, Division of Educational Research and Measurement
AAMC

Waltraut F. Dubé, Assistant Director, for Special Programs, Division of Student Affairs
AAMC

Roy K. Jarecky, Ed.D.
Associate Director, Division of Student Affairs
AAMC

Joseph A. Keyes, J.D.
Assistant Director
Department of Institutional Development
AAMC

James R. Schofield, M.D.
Deputy Director
Department of Institutional Development
AAMC

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

Robert Thompson, Ed.D.
Director, Division of Academic Information
AAMC

Marjorie P. Wilson, M.D.
Director
Department of Institutional Development
AAMC

The meeting was convened in response to the mandate of the Council of Deans expressed in a resolution passed at the 1971 AAMC Annual Meeting and reaffirmed at the mid-year meeting in Chicago on February 5, 1972:

> Resolved: That there be established an ad hoc committee, a task force or other appropriate mechanism to examine the nature and extent of admissions problems and to recommend to the COD ways to ameliorate these problems.

The resolution was stimulated by the recognition that the rapidly increasing number of applications to be processed by each medical school has reached proportions that are placing serious burdens on schools and applicants alike and that serious attention must be devoted to the concomitant problems to ensure that the admissions process is as efficient and equitable as possible.

While the number of first year places has been enlarged substantially since 1960-1961 (from 8,298 to 13,000 presently, an increase of 57%), the number of individuals seeking admission has risen at a much more rapid rate (from 14,397 to 36,302 during the same period, an increase of 153%). At the same time, as the relative difficulty of gaining admission has increased, applicants have sought to improve their chances by increasing the number of schools to which they apply. A total of 245,000 applications are expected to be filed for the entering year 1973-74. As a consequence, schools are frequently called upon to process a volume of applications that exceeds their projected enrollment by 20 to 40 times. The sheer administrative burden of processing these applications and supporting documents is substantial. New files, storage and personnel have been required. Moreover, the task of processing countless papers is merely the beginning. Remaining is the primary function of selecting perspective students with characteristics germane to the educational program of the particular school from an oversized applicant pool.

The current situation presents a series of challenges to the medical schools:

1. To process applications efficiently so that this function is not an undue drain on the institution's resources.

2. To process applications in a fair and equitable manner which ensures each applicant a full opportunity to have his credentials reviewed.

3. To select from the qualified applicants, those who are most likely to contribute to the fulfillment of the objectives of the educational program of the institution.

4. To minimize the financial, academic and emotional cost to the applicant.

5. To assist potential applicants with a realistic assessment of their potential for success in gaining admission to medical school.

The committee has developed a series of recommendations designed to

assist the schools in meeting these challenges.

Recommendations

DEFINE OBJECTIVES

Careful attention should be devoted to defining the mission and objectives of the medical school and specifying the role of the admissions process as it relates to institutional objectives.

ARTICULATE AND PUBLISH SELECTION FACTORS

Factors influencing applicant selection, including minimum cut-off scores and GPA's, should be articulated as explicitly as possible. They should be widely published, consistently expressed wherever they appear and adhered to faithfully in the selection process. Catalogues, Medical College Admission Requirements Handbook entries and AMCAS materials should portray the schools' policies consistently and accurately.

CAREFULLY SELECT AND EDUCATE THE COMMITTEE

Admissions committee members should be carefully selected according to their ability, their commitment to the institution's policies and their willingness to devote the substantial time and energy requisite to the task. This task is of such importance that the decisions require the full participation and consistent attention of each committee member.

Admissions committee members should undertake their assignment only after carefully informing themselves of institutional policies and objectives, the mechanics of the process, and the current state of the art represented by the literature on the subject. Locally organized seminars or briefing sessions might contribute significantly to this objective. The AAMC staff should assist in this by providing appropriate educational material including an annotated bibliography on the subject, and by standing ready to provide consultative assistance on problems within the areas of their expertise.

PROVIDE FULL-TIME SUPPORT

There should be a full-time admissions staff appropriately trained and under the direction of a responsible official of the administration whose sole or primary function consists of providing appropriate assistance to the dean, the admissions committee, and students who apply.

DESIGN PROCESS WITH COSTS IN MIND

Every aspect of the admissions process should be designed with full cognizance of the substantial financial, emotional and academic cost of the process to each applicant. Each step in the process should be designed to minimize these costs and to maximize the return to both the applicant and the institution.

Interviews should be recognized as the most expensive element in the process to the applicant and should be arranged in order

to minimize this expense. All reasonably competitive applicants should be afforded an opportunity to visit the school and be interviewed at their option, but no interview should be required which will not substantially contribute to the selection decision. Where interviews are deemed desirable in cases involving applicants geographically distant from the school, consideration should be given to sending the interviewer to the applicant's locale, rather than requiring each to travel to the school.

A TRAVEL LOAN SUPPLEMENT FEASIBLE?

The cost of travel to interviews is a heavy financial burden on the applicants, particularly on those with limited means. The committee considered this problem and a suggested approach to solving it. To ensure that this burden does not operate to preclude the admission of worthy but financially strained candidates, some mechanism might be developed whereby students would be able to apply for supplementary financial assistance to cover the special costs involved in such travel. A student who has already demonstrated financial need and is receiving student aid should be able to receive further assistance through the regular undergraduate college financial aid office for this purpose. A successful medical school applicant should be able to defray some of these extraordinary costs through a similar process. His medical school student aid officer could take into consideration the accumulated financial obligations which were in part derived from his quest to enter medical school.

The AAMC staff, in conjunction with the GSA, might profitably pursue this suggestion and explore its feasibility.

UNIFORM ACCEPTANCE DATES

The establishment of uniform acceptance dates is a worthy objective. It would facilitate a more consistent review of applications, provide for a more orderly process and minimize the anxiety of applicants associated with the continuing uncertainty of their status. Further efforts should be devoted to surmounting the remaining obstacles to the establishment of uniform acceptance dates.

DECISIONS SHOULD BE TIMELY MADE AND COMMUNICATED

Selection decisions should be announced in accordance with a predetermined schedule and applicants should be promptly informed of their status. Applicants who are clearly not qualified for the work of the school should be indentified early and so informed. Only those who clearly have a reasonable opportunity should be placed on "hold" and their status should be continually re-examined.

POLICIES MUST ACCORD WITH THE PUBLIC TRUST

Admissions policies should be designed with full cognizance of substantial public trust placed in the medical school. This involves recognition of the role of admissions decisions in governing access to the medical profession and the needs of society and particular socio-economic groups for medical services.

AMCAS USEFUL SUPPORT

The Committee was pleased to note the Association's efforts directed toward improving the usefulness to the schools of the American Medical College Application Service (AMCAS). The service, now under the direction of Dr. Robert Thompson, was viewed as having the potential to be of great assistance in the effort to simplify and expedite the applications process. 70 schools will be participating in the program during the academic year 1972-73, as they choose their September 1973 entering class. Those schools which are not yet participating are urged to carefully evaluate the progress of AMCAS as they assess its potential for meeting their future needs.

ADVISORS DESERVE SUPPORT

Pre-medical advisors are in a position to assist potential applicants in assessing their suitability for medical education and to assist medical schools in their assessment of the applicants. The AAMC should continue to devote substantial attention to enhancing the effectiveness of these advisors. Individual medical schools should work closely with these advisors to ensure that they have an accurate understanding of the admissions process, of the demands of medical education, and the nature of the medical profession.

HUMAN BIOLOGY AND HEALTH CAREERS

In view of the increasing interest in health careers among college students, medical educators should cooperate fully in the development of courses in the undergraduate curriculum designed to provide a fundamental understanding of human biology and the full spectrum of health careers available. Such courses would provide substantial assistance to students in making early and appropriate career choices.

GSA IMPORTANT FORUM

The Group on Student Affairs has proved to be an important forum for the exchange of views and information regarding the admissions process and for reaching agreement among the schools on matters requiring a common approach. Deans should be cognizant of this resource and should utilize it to the fullest.

A MATCHING PLAN FEASIBLE?

A matching plan similar in concept to the NIRMP is a possible next step in organized efforts to expedite the application and admissions process. The COD should recommend that the Group on Student Affairs and the AAMC staff begin immediately to explore all aspects of the feasibility of undertaking such a program.

FURTHER STUDIES NECESSARY

The AAMC should continue its studies to determine those characteristics of an applicant which influence not only his ability to successfully complete the medical curriculum, but also those which influence his effectiveness as a physician.

In addition to the matters set out above, the committee considered a number of policy related issues which it found difficult to reduce to specific recommendations. Basic to this aspect of the discussion was the underlying desire to achieve greater confidence that the procedures, policies, standards and decisions could be designed to ensure that admissions determinations produced an optimal match between students selected and the needs of society and the medical profession. No formula was discovered for assuring beyond dispute this kind of result.

The legal challenges being brought against admissions committee decisions were discussed. It was agreed that while legal considerations were important, they should not be viewed with alarm. Mr. Begun has recently surveyed a number of New York State judges regarding their views on a series of issues related to the admissions process. This survey is expected to be published shortly and is commended to your attention. (Attachment I)

The committee recognizes that it has not taken a startling new approach in its recommendations. Many may appear obvious and most are undoubtedly implemented in some fashion at schools around the country. Nevertheless, it is believed that if each school evaluates its procedures against these suggestions, much room for improvement will be found. Consequently, the committee is forwarding its report to the Council of Deans and urges the Council's endorsement. The report is also submitted to the Group on Student Affairs and the Council of Academic Societies for their information and consideration.

8-14-72

Daniel C. Tosteson on behalf of the Association of Chairmen of Departments of Physiology. It was recommended that the resolution which is shown in the minutes (see page 8) be carried to the Resolutions Committee for presentation to the Assembly. The Resolutions Committee did not act favorably.

At the May meeting of the CAS Administrative Board, the following resolution was approved and forwarded to the Executive Council. The Executive Council approved the resolution in principle and forwarded it to the Administrative Boards of the Council of Deans and the Council of Teaching Hospitals. Both of these Boards have approved the resolution and will be presenting it to their Councils. The reso- will be considered at the Assembly meeting on November 4, 1972.

Modern education of both undergraduate and graduate medical students requires an academic environment which provides close day-to-day interaction between basic medical scientists and clinicians. Only in such an environment can those skilled in teaching and research in the basic biomedical sciences maintain an acute awareness of the relevance of their disciplines to clinical problems. Such an environment is equally important for clinicians, for from the basic biomedical sciences comes new knowledge which can be applied to clinical problems. By providing a setting wherein clinical and basic scientists work closely together in teaching, research and health delivery, academic health centers uniquely serve to disseminate existing knowledge and to generate new knowledge of importance to the health and welfare of mankind.

Schools of medicine and their parent universities should promote the development of health science faculties composed of both basic and clinical scientists. It is recommended that organizational patterns be adopted which reduce the isolation of biomedical disciplines from each other and assure close interaction between them.

The Association of American Medical Colleges should vigorously pursue this principle in developing criteria for the accreditation of medical schools.

3. Membership Applications.

The applications for membership into the Council of Academic Societies by the following organizations have been studied and approved by the Administrative Board.

1. Name of Society

American Academy of Neurology

2. Purpose

To stimulate the growth and development of Clinical Neurology by (1) establishing an annual scientific meeting at which clinical and experimental observations on neurological subjects can be presented; (2) establishing a neurological journal for recording clinical and clinically related experimental observations; (3) linking clinical and basic neurological sciences more closely by inviting neurological basic scientists to participate actively in the scientific programs of the Academy; (4) outlining the scope of Clinical Neurology and encouraging recognition of this discipline among the medical profession and in medical schools; (5) establishing a high plane of competence and of clinical value to the literature in Neurology. To stimulate the growth and development of Clinical Neurologists by (1) encouraging the younger members to participate in the scientific and administrative activities of the Academy; (2) encouraging personal relationships and the interchange of ideas between younger Clinical Neurologists and those more senior in the field; (3) encouraging interest among medical graduates to enter Clinical Neurology; (4) furthering personal and scientific contacts between Clinical Neurologists and members of basic neurological fields.

3. Membership

Fellows may be elected only from among physicians (a) who have been certified in Neurology by the American Board of Psychiatrists and Neurologists or by the Royal College of Physicians and Surgeons of Canada and (b) whose chief interest is directed toward practice, teaching, or research in Clinical Neurology; Active members shall be elected from among physicians who have been certified in Neurology by the American Board of Psychiatry and Neurology or by the Royal College of Physicians and Surgeons of Canada.

4. Number of Members

3,382

5. Minutes of the annual business meeting, covering the financial report, committee report, and report from representatives to various committees and councils is available. Date of meeting: April 30, 1970

Copy of the program of the 22nd Annual Meeting of the Academy, April 27-May 2, 1970, is also available.

6. Constitution and bylaws available (included in Membership Directory)

7. Organized

1948

8. Recommendation

9/24/70 - Executive Committee deferred application
10/10/70 - Executive Committee deferred application

Department of the Treasury

MAR - 1971

Internal Revenue Service
Washington, DC 20224

Date: 03-04-71

In reply refer to:

AMERICAN ACADEMY OF NEUROLOGY
4005 W 65TH ST
MINNEAPOLIS, MN 55435

Gentlemen:

Based on the information you recently submitted, we have classified you as an organization that is not a private foundation as defined in section 509(a) of the Internal Revenue Code.

Your classification is based on the assumption that your operations will be as stated in your notification. Any changes in your purposes, character, or method of operation must be reported to your District Director so he may consider the effect on your status.

Sincerely yours,

J. A. Peeler

Chief, Rulings Section
Exempt Organizations Branch

FORM M-0714 (8-70) (CONTINUOUS)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Connie Choate

NAME OF SOCIETY: Association of Orthopaedic Chairmen

MAILING ADDRESS: % James W. Harkess, M.B., Ch.B.
Kosair Professor of Orthopaedic Surgery
University of Louisville
Louisville, Kentucky 40200

PURPOSE: Educational. To foster, promote, support,augment and develop the science of orthopaedic surgery and the teaching of same by providing a forum for discussion of problems related to undergraduate and graduate orthopedics, by providing a mechanism of coordinating and planning activities requiring cooperation between orthopaedic programs and/or orthopaedic residents; and by serving as an active liasion unit between the specialty of orthopaedics and those organizations interested in medical education.

MEMBERSHIP CRITERIA: Chairman of the department, division or section of an AMA approved medical school or a director of an AMA approved and numbered independent orthopaedic residency program.

NUMBER OF MEMBERS: 90 members total, of which 70 on medical school faculty

DATE ORGANIZED: November 19, 1971

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

Nov. 19, 1971 1. Constitution & Bylaws (see attached)

Nov. 19, 1971 2. Program & Minutes of Annual Meeting (see attached)

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

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

   __x__ YES ____ NO

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

   Section 501 (small fee)

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

   ____ a. Approved by IRS

   ____ b. Denied by IRS

   __x__ c. Pending IRS determination

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

(Completed by - please sign)
D. Kay Clawson, M.D.

(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mary H. Derbyshire~~ Connie Choate

NAME OF SOCIETY: The Central Society for Clinical Research, Inc.

MAILING ADDRESS: R 4669 Kresge I, University of Michigan, Ann Arbor, Mich. 48104

PURPOSE: The objectives of the Corporation are the advancement of medical science; the cultivation of clinical research by the methods of the natural and behavioral sciences; the correlation of science with the art of medical practice; the encouragement of scientific investigation by the medical practitioner; the diffusion of a scientific spirit among the members of the Corporation; the sponsorship of scientific meetings; and the publication, without profit to the Society, for national and international distribution, of papers on the methods and results of clinical research.

MEMBERSHIP CRITERIA: Members may be elected from residents of the following states of the United States of America: Alabama, Arkansas, Colorado, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Western New York and Western Pennsylvania; and from the following provinces of Canada: Alberta, Manitoba, Ontario and Saskatchewan. Any resident in the territory set out in the above, who has accomplished a meritorious original investigation in the clinical or allied sciences of medicine and who enjoys an unimpeachable moral standing in his profession is eligible for active membership. Except in unusual circumstances, no one shall be admitted to active membership who is over the age of forty-five years.

NUMBER OF MEMBERS: 829 active members, 386 emeritus members = 1,215 total membership.

DATE ORGANIZED: First Annual Meeting held in November, 1928. Society was incorporated in November, 1966.

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

November, 1966 1. Constitution & Bylaws

November, 1971 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

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

X YES ____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested:
Section 101(6).

Section 101(6)

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

X a. Approved by IRS

____ b. Denied by IRS

____ c. Pending IRS determination

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

(Completed by - please sign)

May 12, 1972
(Date)

Secretary - Treasurer, CSOR

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mary Xxxxxxxxxxxx~~ Connie Choate

NAME OF SOCIETY: The American College of Psychiatrists

MAILING ADDRESS: c/o Peter A. Martin, M.D., Secretary-General
16300 North Park Drive Suite 115
Southfield, Michigan 48075

PURPOSE: To provide professional leadership and promote, maintain, and support the highest standards in psychiatry through teaching, training and research.

To provide a forum for the discussion of subjects pertaining to the field of Psychiatry, leading to the best application and utilization of psychiatric knowledge, principles, and therapy and to the development of increased public understanding and support. The College strive to advance national and international acceptance of eclecticism in various areas of psychiatric knowledge. To participate in programs of education, of service to the public, and foster the highest level of ethics in the practice of psychiatry.

MEMBERSHIP CRITERIA:

Evidence of outstand ing performance in teaching, research, publications, therapy, administation or community activity. Evidence of leadership in such areas for Fellows and promise of leadership for members.

NUMBER OF MEMBERS: 400

DATE ORGANIZED: May 8, 1963

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

1971 1. Constitution & Bylaws

May 1, 1971 Program & Minutes of Annual Meeting

(CONTINUED . OVER)

QUESTIONNAIRE FOR TAX STATUS

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

✓ YES ____ NO

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

501 (c) 3

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

X a. Approved by IRS

____ b. Denied by IRS

____ c. Pending IRS determination

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

Peter G. Martin, M.D.
(Completed by - please sign)

5-4-72
(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mary Ann Lucchesi~~ Connie Choate

NAME OF SOCIETY: BIOPHYSICAL SOCIETY

MAILING ADDRESS: Dr. Margaret O. Dayhoff, Secretary
Biophysical Society
National Biomedical Research Foundation
Georgetown University Medical Center
3900 Reservoir Road, N.W.
Washington, D. C. 20007

PURPOSE:

The purpose of the BIOPHYSICAL SOCIETY is to encourage development and dissemination of knowledge in biophysics.

MEMBERSHIP CRITERIA:

Membership in the BIOPHYSICAL SOCIETY shall be open to scientists who share the stated purpose of the society and who have educational, research, or practical experience in biophysics or in an allied scientific field.

NUMBER OF MEMBERS: 2,211

DATE ORGANIZED: Feb. 1958

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

Oct. 29, 1971 1. Constitution & Bylaws
Feb. 24-27, 1972 2. Program & Minutes of Annual Meeting

} Sent under separate cover.

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

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

   X YES ___ NO

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

   501(c)(3)

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

   X a. Approved by IRS

   ___ b. Denied by IRS

   ___ c. Pending IRS determination

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

(Completed by - please sign)

(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: ~~Mxxx Hxxbxxtxxxxxxx~~ Connie Choate

NAME OF SOCIETY: American College of Radiology

MAILING ADDRESS: 20 N. Wacker Drive
Chicago, Illinois 60606

PURPOSE: Professional organization composed of physicians certified by the American Board of Radiology. The American College of Radiology was incorporated in 1924 under the laws of the State of California to make available to American radiologists continuing education programs and study socio-economic developments as they affect radiology.

MEMBERSHIP CRITERIA: Completion of residency in radiology, certification by the American Board of Radiology in radiology by the Royal College of Physicians and Surgeons (Canada); membership in State Chapter of the College.

NUMBER OF MEMBERS: 8,000

DATE ORGANIZED: 1923

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

June, 1972 1. Constitution & Bylaws

April 3, 1972 and June 14, 1972 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

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

   x YES ____ NO

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

   501 (c) (3)

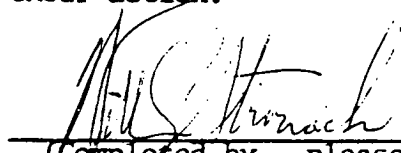
3. If request for exemption has been made, what is its current status?

   x a. Approved by IRS

   ____ b. Denied by IRS

   ____ c. Pending IRS determination

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



(Completed by - please sign)
Executive Director
July 27, 1972
(Date)

4. Election of Officers and Administrative Board Members.

At the last election of officers and members in October 1971, it was recommended that a biographical sketch of each nominee be included in the ballot. These sketches have been obtained from standard directories and contain the information on each individual previously published and in the public domain.

Chairman-Elect, CAS (One to be elected)
One-year term

Carmine D. Clemente

CLEMENTE, CARMINE DOMENIC, educator; b. Penns Grove, N.J., Apr. 29, 1928; s. Ermanno and Caroline (Friozzi) C.; A.B., U. Pa., 1948, M.S., 1950, Ph.D., 1952; postdoctoral fellow U. London, 1953-54; m. Dorothy Warren, Dec. 19, 1955 (div.); m. 2d, Juliette Vance, Sept. 19, 1968. Asst. instr. anatomy U. Pa., 1950-52; faculty U. Cal. at Los Angeles, 1952—, 53, prof., chmn. dept. anatomy, 1963—. Hon. research asso. Univ. Coll., U. London, 1953-54; cons. Sepulveda VA Hosp., NIH. Mem. med. adv. panel Bank Am.-Giannini Found. Mem. Pavlovian Soc. N.Am. (Ann. award 1968, pres. 1972), Brain Research Inst., Am. Physiol. Soc., Am. Assn. Anatomists (v.p. 1970-72), Am. Acad. Neurology, Am. Acad. Cerebral Palsy, Biol. Stain Commn., Internat. Brain Research Orgn., Med. Research Assn. Cal., N.Y. Acad. Sci., Nat. Acad. Sci. (mem. com. neuropathology, BEAR coms.), Sigma Xi. Democrat. Methodist. Author: Aggression and Defense: Neurol Mechanisms and Social Patterns, 1967; Physiological Correlates of Dreaming. Asso. editor Experimental Neurology, Anatomical Record, Conditional Reflex. Contbr. articles to sci. jours. Home: 11737 Bellagio Rd Los Angeles CA 90049

Ronald W. Estabrook

ESTABROOK, RONALD (WINFIELD), b. Albany, N.Y. Jan. 3, 26; m. 47; c. 4. BIOCHEMISTRY. B.S, Rensselaer Polytech, 50; U.S. Pub. Health Serv. fel. & Ph.D.(biochem), Rochester, 54. Fel, Johnson Found. Med. Physics, Univ. Pa, 54-57, res. assoc, 57-58, asst. prof. phys. biochem, 59-61, assoc. prof, 61-65, prof. 65-68; VIRGINIA LAZENBY O'HARA PROF. BIOCHEM & CHMN. DEPT, UNIV. TEX. SOUTHWEST. MED. SCH, DALLAS, 68- Fel. Am. Heart Asn, 57-58; U.S. Pub. Health Serv, 58- U.S.N.R, 44-58, Lt.(jg). Am. Chem. Soc; Fedn. Am. Socs. Exp. Biol; Am. Soc. Biol. Chem. Application of physical methods to study of intracellular biochemical processes. Address: Dept. of Biochemistry, University of Texas (Southwestern) Medical School, Dallas, TX 75235.

Administrative Board (One to be elected)
Two-year term

Rolla B. Hill, Jr.

HILL Rolla B Jr Cert Path (PA) 59 (CP) 60. b 29 Balt. MD Roch 55. Intern (O State U Hosp Columbus) 55-56 Path Fell (Roch) 52-53 Trng (3d USA Med Lab Ft McPherson Ga) 56-58 Path Res (Yale) 58-59 Asst Path 59-60 Assoc Path 60-61 (Bridgeport Hosp). Clin Instr (Yale) 59-61 Asst Prof Path 61-65 Assoc Prof Path 65-68 Prof Path & Assoc Dean 69-- (Colo) Prof & Vice Chm Path (U Cal Davis) 68-69. Capt USA 56-58 ASEP-AAPB-IAPath-Am S Cell Biology-Alpha Omega Alpha. U Colo Med Center Denver CO

R. Walter Schlesinger

SCHLESINGER, ROBERT WALTER, microbiologist; b. Hamburg, Germany, Mar. 27, 1913; s. Emil and Flora (Srelitz) S.; student U. Hamburg Med. Sch., 1931-34; M.D., U. Basel, Switzerland, 1937; m. Adeline P. Sacks, Jan. 7, 1942; children—Robert, Ann. Came to U.S., 1938, naturalized, 1943. Guest Investigator Inst. Bacteriology and Hygiene, U. Basel, 1937-38; intern Beekman Hosp., N.Y.C., Stamford (Conn.) Hosp., 1938-40; fellow, asst. pathology and bacteriology Rockefeller Inst., N.Y.C., 1940-46; asso. research prof. pathology, head virus research lab. U Pitts. Sch. Medicine, 1946-47; asso. mem., div. infectious diseases Pub. Health Research Inst., City of N.Y., Inc., 1947-55; prof., dir. dept. microbiology St. Louis U. Sch. Medicine, 1955-63; prof., chmn. dept. microbiology, Rutgers Med. Sch., Rutgers U., New Brunswick, N.J., also acting dean. Cons., Sec. War, 1946. Served as capt., M.C., AUS, 1944-46. Mem. Am. Acad. Microbiology, Am. Assn. Immunologists, Am. Soc. Microbiology, Am. Soc. Cancer Research, A.A.A.S., N.Y. Acad. Sci., Nat. Insts. Health Virology Study Section, Sigma Xi. Author sci. publs. Editor: Virology. Home: 802 East Meadow Dr Bound Brook NJ 08805 Office: Rutgers Med Sch New Brunswick NJ 08903

Administrative Board (Two to be elected)
Two-year term

Robert M. Blizzard

BLIZZARD Robert Martin Cert Pd 57. b 24 East St Louis Ill. MD Northwest 52. Intern (Iowa Meth Hosp Des Moines) 52-53 Res Pd (Raymond Blank Meml Hosp for Children Des Moines) 53-55 Clin & Research Fell Pd Endocrin (Johns Hop Hosp) 55-57. Assoc Prof Pd & Asst Prof Med (O) 57-60 Assoc Prof Pd 60-67 Prof Pd 67-- (Johns Hop). Johns Hopkins Hosp Baltimore MD 21205

David R. Challoner

CHALLONER David Reynolds Cert M 68 b 35 Appleton Wis. MD Harvard 61. Med Intern 61-62 Asst Med Res 62-63 (both at Colum-Presbyn Hosp NYC) Chief Res Med (King Co Hosp Seattle) 65-66 Research Assoc Lab Metabolism (Natl Heart Inst-NIH) 63-65 Research Fell Div Endocrin (U Wash Seattle) 66-67 Att Phys (Robert Long Hosp-Ind Med Center) 67-- (VA Hosp-Ind Med Center) 67-- Chief Div Endocrin (Marion Co Gen Hosp) 70--. Asst Prof Med & Biochemistry (Ind) 67. Lt Comdr USPHS 63-65 AFCR-CSCR-ADiabA-APhysiolS-EndocrinS. Ind Sch Med 1100 W Michigan St Indianapolis IN 47202

Howard Hiatt

HIATT Howard Cert M 55. b 25 Patchogue NY. MD Harvard 48. Intern 48-49 Asst Res Med 49-50 Phys-in-Chief (all Beth Israel Hosp Boston) Research Fell Med (Cornell-NY Hosp) 50-51 & 52-53. Prof Med (Harvard). Sr Asst Surg to Surg USPHS 50-55. AAAS-ASCI-AAP-ACP(F). 330 Brookline Ave Boston MA 02215

William P. Longmire, Jr.

LONGMIRE William P Jr Cert S 47. b 13 Sapulpa Okla. MD Johns Hop 38. Intern 38-39 Asst Res 42-44 Res Surg 44 Surg in Charge Outpatient Clin PI Surg (all at Johns Hop Hosp) Harvey Cushing Fell Exptl Surg 39-40 Halsted Fell Surg Path 40 (both Johns Hop) Cons Surg (Wadsworth VA Hosp LA) (Harbor Co Gen Hosp Torrance Cal) Chief Surg Cons (USAFE) 52-54 Nat Civilian Surg Cons to Surg Gen (USAF) 54-- Civilian Cons to Surg Gen (USA) 60--. Guest Prof Surg (Free U Berlin) 52-53 Asst Surg Instr Surg 43-45 Asst Prof Surg 45-47 Assoc Prof Surg 47-48 (all at Johns Hop) Prof Surg & Chm Dept Surg (CalifLA). Med Sch U Cal Los Angeles CA 90024

BALLOTING WILL BE BY WRITTEN BALLOT AT THE CAS BUSINESS MEETING

V. Discussion Items:

1. Present and future policy trends of NIH and NIMH training grant programs.

In recent weeks there has been considerable discussion between the AAMC and various sections of the Federal Government involved in training-grant policy development. The Executive Council met with Mr. Paul O'Neil, Assistant Director of the Office of Management and Budget for the HEW budget, and members of the staff met with members of Mr. O'Neil's staff on October 6th. On October 17th, the members of the CAS Administrative Board met with Dr. Kenneth Crispell, special consultant to the Director of NIH and with Dr. Marston. Reports of these meetings and policy trends will be discussed. The recent IRS ruling regarding taxability of fellowship stipends will also be reviewed.

2. Student and Faculty Participation in Educational Exercises Involving "Private Patients".

With diminishing dependence upon indigent patients for teaching and increasing dependence upon "private patients" for clinical educational experiences, there are moves toward limiting the active participation of both undergraduate and graduate medical students and their teachers in the process of patient care in the private setting. Dr. James V. Warren will discuss these issues.

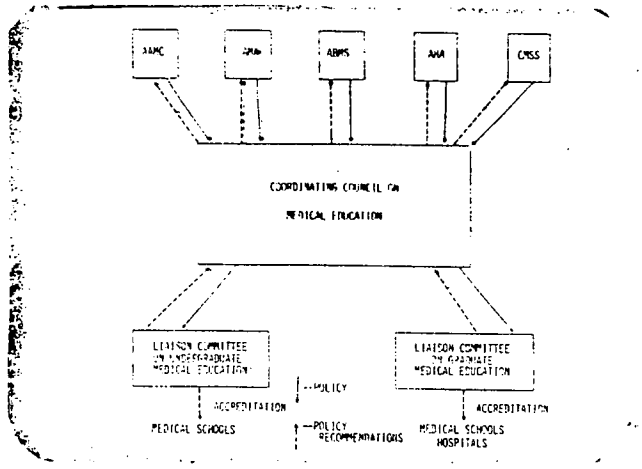
3. Programs and Progress in the Conquest of Cancer.

Dr. Jonathan Rhoads is a member of the National Cancer Advisory Board to the National Cancer Institute. The Conquest of Cancer Program has been in operation for approximately one year. Dr. Rhoads will report on the general developments and progress in achieving the goals of the program.

4. Accreditation of Medical Schools and the Future of Accreditation of Graduate Clinical Education.

Accreditation of medical schools for their undergraduate medical programs has been the joint responsibility of the AMA and the AAMC since 1942 . Through the Liaison Committee on Medical Education, these organizations periodically survey and review all aspects of institutions conducting educational programs leading to the M.D. degree. Recently the rapid growth in new schools and the changing programs in old schools has led to a significant increase in the responsibilities of the LCME. The increased participation of the Federal sector in supporting medical education has also led to questions of authority and responsibility for accreditation decisions. A discussion of the scope of activities and the problems now facing the LCME will be presented.

The Liaison Committee on Graduate Medical Education, first reported upon at the February 1972 Council meeting, has now officially been adopted by all five sponsoring organizations. The Coordinating Council has also been adopted. The diagram below illustrates the relationship of these two new bodies to their parent organizations and to the existing LCME.



Appointments have been made by most parent organizations to the LCGME and the Coordinating Council. The appointees are on pages 35 and 36.

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

American Board of Medical Specialties:

Dr. Gordon Douglas - Obstetrics
Dr. Robert Chase - Plastic Surgery
Dr. Jack Myers - National Board of Medical Examiners
Dr. John Anderson - Pediatrics

American Hospital Association:

Dr. Samuel Asper
Dr. Bruce Everest

American Medical Association:

Dr. William Sodeman
Dr. James Haviland
Dr. Bernard Pisani
Dr. Perry Culver

Association of American Medical Colleges:

Dr. William Anlyan
Mr. John Danielson
Dr. Julius Krevans
Dr. William Holden

Council of Medical Specialty Societies:

Dr. Edward Rosenow
Dr. Rubin Flocks

COORDINATING COUNCIL ON MEDICAL EDUCATION

American Board of Medical Specialties:

Dr. John Roach - Radiology
Dr. John Hubbard - National Board of Medical Examiners
Dr. Robert Chase - Plastic Surgery

American Hospital Association:

Dr. Thomas Ainsworth
Dr. Don Caseley
(Third representative to be named)

American Medical Association:

Representatives will be elected by the AMA House of Delegates at its Clinical Convention in November.

Association of American Medical Colleges:

Dr. William Anlyan
Dr. Clifford Grobstein
Dr. T. Stewart Hamilton

Council of Medical Specialty Societies:

Dr. William Sodeman
Dr. Jerome Wildgen
Dr. Rollins Hanlon

COUNCIL OF ACADEMIC SOCIETIES

INDIVIDUALIZED MEDICAL EDUCATION

Flexibility in academic programming for undergraduate medical students is becoming the rule rather than the exception. This movement toward tailoring education and training to the needs of the students is also spreading into graduate medical education. Absolute course requirements are diminishing as elective opportunities increase. Some schools are allowing students to arrange individual programs to suit their own pace of learning. The flexibility provided by these changes enhances genuine individualization of medical education and training.

The Council of Academic Societies, representing a membership responsible for the education and training of American physicians, is holding a workshop to assess the current state of individualized programming for undergraduate and graduate medical students. Major goals of the workshop include the exploration of methods for evaluating student achievement, and the development of ideas and recommendations which will insure that meaningful individualization will not compromise the quality of students' preparation for a medical career.

What are the advantages and disadvantages of individualization to both students and faculties?

Does individualization potentiate selection and graduation of students from a wider range of applicant pool (e.g. minorities and women)?

Do advance-placement programs really work? If so, for what catagories of students? Are they predominantly successful only with bioscience majors or can students who have pursued other majors take advantage of this kind of acceleration? Can advance placement be facilitated by national achievement exams in specific subject areas?

What methods of evaluation can be employed to assure that the overall objectives of education for medicine have been fulfilled?

Does individualization promote greater diversity, or do students and faculty continue in conservative patterns and reproduce traditional curricula?

Can individualization be made more cost-effective if schools promote exchange-student programs, thus providing

additional enrichment of student opportunities without excessive course development in each institution?

Do self-instructional and computer-assisted programs prove effective in facilitating individualization?

Can individualization be carried across the boundary between undergraduate and graduate medical education? If students' undergraduate programs are correlated with their graduate programs, does this lead to a narrowing of experience or can reasonable breadth be assured?

These are only a few of the questions raised by current trends toward increased flexibility in American medical education. The workshop will bring together representatives from 51 member societies of the CAS and representatives from the medical schools, particularly those charged with the administration and management of innovative programs.

To accomplish the goals of the workshop, the attached format and topics will be used. It should be noted that the descriptors are directed toward insuring that speakers and workshop chairmen concentrate on the current experiences and outcomes of experiments in individualization. It is intended that the workshop attendees should carry away a greater understanding of both the advantages and the problems of curriculum flexibility and individualization.

It is anticipated that the workshop will provide an opportunity to identify the real problems created by individualization. Special studies and services to solve these problems can be then planned.

It is expected that 150 or 175 individuals will attend the conference which is presently planned for the Monte Leone Hotel in New Orleans, Louisiana, in late March 1973.

CAS WORKSHOP

Preliminary agenda

Thursday

6:00 p.m. Reception

7:00 p.m. Dinner

8:00 p.m. Keynote speaker and discussion of workshop format.

The keynote speaker will be a distinguished educator who can discuss concepts of individualized education both from the standpoint of students and their varied learning styles and institutions with their concrete limitations. The societal value of individualization for medical education extending from high school through certification by a specialty board will be explored.

Friday

8:30 a.m. "The Range of Individualization Now Provided in Medical School Curricula" L. Thompson Bowles AAMC

A detailed survey of all medical curricula in the U.S. and Canada has been completed. Copies of the survey will have been distributed to all participants. Dr. Bowles will have investigated the various types of flexible programming now provided and collated the experiences in general terms. For example, the average proportion of total academic programs set aside for electives with high and low ranges will be available. In selected schools, the distribution of elective choices by departments and disciplines can be developed to demonstrate the impact of elective programming on segments of the faculty. The proportion of schools which allow flexible timing of progress through medical school can also be reported. Several other parameters related to individualization will be presented.

9:00 a.m. Discussion

Friday, cont.

9:15 a.m. "An Evaluation of Experiences at the Ohio State Pilot Medical School" _____ - Ohio State

For three years, a self-selected group of students at Ohio State have been enrolled in a special program which permits their learning medicine outside the conventional classroom and at their own pace. The particular usefulness of the computer and the problems attendant on the development of the computer programs will be presented. How the students, the faculty and the computer interact will be described. The effect of this experimental model on students' behavior with particular concentration on their rate of progress and the opportunities provided for either accelerated or decelerated academic programs will be detailed.

9:45 a.m. Discussion

10:00 a.m. "An Evaluation of Experiences With An All-Elective Curriculum at Stanford" _____Stanford

Stanford students plan their entire undergraduate medical education individually. The range of programmatic variation which has resulted at Stanford will be of special interest. The response of the faculty in providing increased numbers of elective courses to meet students' needs will be reported. The way in which students budget their time when no courses are required is also of significance and will be described. The opportunities which an all-elective program provides for students with unusual backgrounds will be considered.

10:30 a.m. Discussion

10:45 a.m. Coffee break

11:00 a.m. "An Evaluation of Experiences With Early Career Tracking at _____"

A few schools have provided students with the opportunity to tailor their undergraduate

Friday, cont.

curricula to their perceived career plans. Early tracking has been criticized by those who believe students should be permitted a prolonged, broad experience before making a decision regarding specialty choice and career direction. A school will be identified which has a sufficient length of experience to provide answers to the following questions:
1. Does early tracking make students unduly anxious?
2. What portion of students can make sufficiently discriminatory decisions by the end of their introductory clerkships and thus select a career track?
3. Do students who change their minds after starting down a career track pay a significant penalty in lost time?
4. Can early tracking be coordinated with graduate clinical training programs and thus hasten the entrance of well-prepared students into practice?
5. Can early tracking be programmed to insure breadth or is narrowness of experience always the outcome?

11:30 a.m. Discussion

11:45 a.m. "Individualization for Students With Unusual Backgrounds at _____"

Minorities, women with family responsibilities and students from the humanities and behavioral and social sciences may particularly benefit from individualized programming. The experience of a school which provides individualized programs for these types of students will be reported. The value of prolongation of education for these individuals will be considered in the context of the ultimate social value of the effort.

12:15 p.m. Discussion

12:20 p.m. Lunch

Friday, cont.

2:00 p.m. Workshops Convene

Each workshop will be limited to 1/6 of the total participants. Participants will be permitted to rank their order of interest in the workshops in advance and will be assigned to the workshop of their highest priority within the limits imposed by the 1/6 rule.

Workshop co-chairmen and recorders will be asked to develop further the questions raised in the descriptors and where possible, find and provide data in advance to the workshop participants. Every effort will be made to utilize the real experiences of individuals and institutions.

WORKSHOP #1

Developing An Array of Electives Which Meet Student Needs

A representative from Stanford

A representative from _____

L. Thompson Bowles, M.D., Recorder

Elective course demands can place a heavy teaching load on the faculty and exceed the clinical teaching facilities available in the institution. What are the experiences with elective planning? How do the periods of time available for electives jibe with accomplishing the objectives of the educational experience? Are there definable minimums of time for effective elective teaching? How can effective, high-quality electives be developed utilizing physician-teachers and clinical resources outside the conventional medical center? How can basic science electives be developed which are relevant, of high quality and attractive to students who are already in their clinical years? Are clinical electives, in the first months of medical school, academically sound; or are they "show and tell" experiences designed to satisfy student curiosity?

WORKSHOP #2

Academic and Career Counselling

A representative from _____

A representative from _____

Roy K. Jarecky, Ed.D., Recorder

Individualization requires that students be provided with sound advice regarding their career goals and know-

WORKSHOP #2, contd.

ledgeable counselling regarding their educational program planning. How can institutions develop a cadre of experienced faculty advisors? How can students be brought to respect the advice and counsel available? Are there formal test instruments which can be employed to determine whether students are making appropriate career decisions? Should advisors participate in the evaluation of their advisees and write letters of recommendation?

WORKSHOP #3

The Present Need and Future Means for Assessment of Achievement

A representative from NBME

A representative from

James B. Erdmann, Ph.D. - Recorder

When all students were required to take essentially the same courses, great dependence was placed on course-by-course grade compilation and rank ordering in assessing student achievement. With individualization, there are fewer constants, and evaluation of achievement through comparison of students within their own class is impossible. How can achievement be evaluated to insure that each student has met standards of optimal preparation? Do educational objectives have to be more specifically defined? What is the optimal timing of evaluation--at the completion of the academic program, or at particular intervals before completion? Are learning exams useful? What about pretesting? Does the National Board exam prove useful? Is the inter-institutional sharing of test items desirable? How can adequate written evaluation of students' knowledge, skills and attitudes be obtained from the faculty? Without class ranking, can accurate letters of recommendation be written?

WORKSHOP #4

Self-Instructional Program Development

A representative from Southern Consortium

A representative from _____

William G. Cooper, Ph.D. - Recorder

WORKSHOP #4 contd.

Self-instruction would appear to provide opportunities for maximizing independent student learning and thus permit greater individualization. Can self-instruction be utilized in lieu of formally-scheduled classes? How does one develop a self-instructional package? Are multimedia needed? How complex must they be? Can self-instructional material be used to augment the learning of students whose learning styles are more dependent on voice and graphics? What facilities are needed to utilize self-instructional materials? How can a faculty member locate self-instructional materials available nationally? At what costs?

WORKSHOP #5

Articulation With The Undergraduate College Experience

A representative from _____

A representative from _____

Davis G. Johnson, Ph.D. - Recorder

Students are coming to medical school with varying types of preparation. By individualizing, can students from a broader variety of disciplines be brought into medicine? Can students with specific preparation in the biomedical sciences be allowed a more rapid rate of progress? What are the communication barriers between college and medical school faculties which inhibit adequate advice and counselling of students intent on medicine? Should American medical education move toward greater flexibility in timing of entrance into medical school? If so, what additional data is needed to permit selection out of high school, or during the first or second year of college?

WORKSHOP #6

Extending Individualization Across The Boundary Between Medical School and Graduate Medical Education

A representative from orthopedics or ob.-gyn.

A representative from _____

Michael F. Ball, M.D. - Recorder

Individualized educational programming will be of little value and personally frustrating if students find that gradu-

ate clinical
WORKSHOP #6 contd.

ate clinical programs are rigid and unyielding. What is occurring in graduate medical education? Are training program directors developing their plans in order to take advantage of early tracking? How are graduate programs assessing levels of student achievement? How will they provide for makeup of deficiencies? Can graduate program directors be given a responsibility to certify that students have achieved optimal skills? How must Board requirements and examinations be modified to achieve optimal flexibility in academic programming?

5:30 p.m. Workshops adjourn

6:30 p.m. Reception

7:30 p.m. Free evening

Saturday

8:30 a.m. Workshops reconvene for summary discussion and preparation of final reports.

10:00 a.m. Coffee

10:15 a.m. Plenary session, recorders' reports on Workshops

11:45 a.m. General discussion

12:30 p.m. Adjourn

ESSENTIALS FOR EDUCATION OF THE PHYSICIAN'S ASSISTANT

The document which follows has been received by the Liaison Committee on Medical Education from its Subcommittee on Physician's Assistants, July 12, 1972.

The document has not been approved by the LCME but has been forwarded by it to the parent councils for their consideration and comment. The LCME will consider any suggested amendments proposed by the AAMC Executive Council and the CME prior to full LCME Action.

The document was approved by the Executive Council on September 15, 1972.

April 25, 1972 LCME Subcommittee
Type A, Physician's Assistants
Revision 7/12/72 DRAFT
Sent to the Executive Council for comment 8-18-72

ESSENTIALS FOR EDUCATION OF THE PHYSICIAN'S ASSISTANT

I. Introduction

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

It is intended that these Essentials for Education of Physician's Assistants be used as the basis for development of educational programs that can provide assurance to the medical profession and to society that the graduates are competent to receive nation-wide public recognition and acceptance as members of the expanding team of health care occupations and professions.

II. Sponsorship

The nature of the Physician's Assistant's role, his/her clearly defined and close working relationship with the physician, the distinctions between functions performed by the Physician's Assistant and the physician all combine to force the conclusion that there should be a very close relationship between the education of the physician and that of a Physician's Assistant. The consequences of this conclusion are that the Physician's Assistant is to be educated in a medical school-academic medical center, or health science center, in a program under direction of a faculty of physicians and basic medical scientists. A substantial part of the training should be done in a well-developed teaching hospital engaged in house staff training.

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* Adopted by the House of Delegates of the American Medical Association on _____, and the Assembly of the Association of American Medical Colleges on _____.

This would not automatically preclude the development of programs at settings other than medical schools but would require a similar concentration of teaching physicians and clinical facilities involved in some phase of physician education.

There must be evidence that the program has education as its primary orientation and objective.

III. Educational Goals

The educational program should be structured so as to prepare the physician's Assistant to function under direct supervision of a responsible physician; but, under special circumstances and legally derived rules, the Physician's Assistant should be prepared to perform defined functions with indirect supervision by the physician via modern methods of communication. To be able to perform at this level, the Physician's Assistant must complete a well-developed educational program in medicine sufficient to permit a degree of interpretation of clinical findings and some degree of independent action.

Thus, the educational program must prepare the Physician's Assistant to utilize the skills needed to approach the patient, to communicate effectively in the collection of historical and physical data (the data base) and in presentation of them in such a way that the physician can accurately visualize the medical problem and proceed to determine the appropriate sequence of diagnostic and/or therapeutic steps for his/her patient, thereby conserving time for use in verifying findings and extending professional contact with the patients.

The educational program should prepare the Physician's Assistant to perform diagnostic and therapeutic procedures in common use by

physicians. The program should include instruction in quantitative skills sufficient to insure ability to do accurate calculation and analysis of tests and procedures.

The program should prepare the Physician's Assistant to carry out the physician's patient-care plan and/or actively interpret this plan to the patient.

The educational program should train the Physician's Assistant to coordinate the functions of other more technically and less broadly trained assistants to the physician.

IV. Administration

The program should be under the supervision of a qualified director who should be a physician who has available the faculty and resources necessary to develop effective systems of student selection, a suitable curriculum and means of evaluation thereof, methods of academic evaluation of students, and councelling and career guidance of students. The Director should have a clearly defined relationship with authorities of the sponsoring educational institution, and the participating teaching hospitals. There should be appropriate mechanisms for faculty participation in governance and in development of curriculum and education policies.

V. Faculty

The program must have a clearly designated faculty competent to provide the basic science and clinical teaching which comprise the curriculum. The faculty may include instructors other than physicians, but there must be a significant learning experience under the supervision of clinicians so as to insure understanding of patients, their problems, their reactions to these problems, and the customary diagnostic and therapeutic approaches toward solution of these problems.

VI. Facilities

The sponsoring institution must provide adequate space and modern equipment for all necessary teaching functions. A library, containing up-to-date textbooks, scientific and clinical periodicals and reference material pertaining to the broad field of clinical medicine and its supporting disciplines should be readily accessible to students and faculty.

VII. Finances

The program should be based on a stable operating budget adequate to meet the requirements set forth in this document. Financing should be derived from diverse sources. Tuition fees should not be the sole source of income.

VIII. Educational Program

The curriculum must provide adequate instruction in the basic sciences underlying human medicine. These include normal human structure and growth, major organ and specialized tissue function, response of the human organism to injury, including that by infectious agents, the nature of disease processes and the process of development of signs and symptoms. The social and cultural determinants of health should be stressed.

These studies must be combined and illustrated with instruction, observation, and supervised participation in

A. The development of the data base; i.e.

(a) recording of the patient's chief complaint

(b) description of the patient's typical daily habits and other pertinent social data.

(c) definition of the nature of the present illness or illnesses.

(d) eliciting of past history of illness and prior and current therapy by review of systems according to a uniform series of logically arranged and explicit questions.

(e) recording of results of a physical examination of defined content.

(f) administration of or arrangement for laboratory examinations and analysis of results.

and

B. Diagnostic and therapeutic procedures and other responsibilities in patient care usually accepted by the physician.

Emphasis must be placed on instruction in practical communication skills for use with patients and other members of the health care team.

The close professional working relationship between a Physician's Assistant and physicians should be emphasized in the educational program by providing learning experiences which bring together Physician's Assistant students and undergraduate and graduate medical students. Such exercises can be developed in the clinical setting in the context of both ambulatory and hospitalized patient care.

There must be sufficient evaluative procedures to assure adequate evidence of competence to meet the objectives of the educational program and to allow the graduate to perform effectively in this health career.

The basic program must insure that the graduate possesses a broad general understanding of medical practice and therapeutic techniques;

however, the student may supplement his/her basic studies through extra investment in a particular specialty of medicine.

The level of responsibility proposed for the graduate of this program requires an adequate academic as well as a practical basis. The applicant will present two years of college credit or credit obtained through equivalency examination. These credits should include studies in the sciences of biology, chemistry and mathematics, as well as a cluster of liberal arts and social studies, including English composition.

The duration of this program of instruction should be a minimum of 24 months. All courses of instruction should be rated for university academic credit. Effort should be made to include in the curriculum some experience with use of self-instructional learning systems.

The graduates of this program should be granted sufficient credential to recognize the scope of their achievements.

The graduates would be awarded the baccalaureate degree or its equivalent, based upon the substance of this program as well as its academic prerequisites.

IX. Selection of Students

It is expected that students seeking careers as Physician's Assistants will have significant motivation toward serving in a role which provides close personal, human interaction. The process of selection should be efficient, fair and impartial. There should be no discrimination on the basis of sex, creed, race or national origin. Attention should be given to each applicant's prior academic record, experience in health related occupations, admission test scores, evidence of good character and ethical behavior, mental stability,

maturity, and general fitness for prospective assignment of responsibility in the sensitive field of medical care for humans.

X. Accreditation

The Liaison Committee on Medical Education was established in 1942 out of an administrative union of accreditation efforts beginning before this century by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. The Liaison Committee expects to incorporate the process of accreditation of programs in education of the Physician's Assistant along with its historic and universally recognized exercise of approval over the medical schools of this country.

Procedures:

(1) Newly established programs will be reviewed initially by a team sent out for that purpose.

(2) Subsequent reviews will be accomplished as an aspect of a medical school-center institutional accreditation site visit.

(3) A standing committee of the LCME will be charged with primary supervision over the Physician's Assistant program accreditation, with final approval reserved to the LCME on the recommendation from this committee.

(4) The director of each program will be required to submit an annual report to the LCME in response to a formal questionnaire.

6. Tax exempt status--its complexities and needs for uniform status for AAMC constituents.

The following information was supplied by the Association's attorney in an effort to clarify the difference between organizations exempt under Section 501(c)3 of the Internal Revenue Code as opposed to those exempt under 501(c)6.

Section 501(c)3 organizations are those which are organized and operated exclusively for religious, charitable, scientific, educational or other specified purposes, all of which may be for the benefit of the general public or a group more comprehensive than the entities or individuals comprising the membership. Moreover, these organizations are not permitted to engage in any substantial activities which include carrying on propaganda or otherwise attempting to influence legislation or political campaigns.

Section 501(c)6 organizations are defined as business leagues, Chambers of Commerce, real estate boards, boards of trade, and professional football leagues. In fact, the Internal Revenue Service seems to have classified as 501(c)6 organizations some entities which are clearly entitled to operate free of the burdens of Federal income taxes and, yet, do not easily fit any of the categories specifically mentioned in Section 501(c).

Specifically, however, Section 501(c)6 organizations are those whose purpose is to promote a common interest of its members. Its activities may be directed toward the improvement of business conditions common to a particular industry. These purposes are more limited than those which are typically the primary objectives of a 501(c)3 organization. The 501(c)6 entities may be thought of as being more self-interested, although, of course, like 501(c)3 organizations, they cannot be organized or operated in a manner which would benefit directly any individual.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

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

DATE October 27, 1972

TO: Members of the Council of Academic Societies

FROM: August G. Swanson, M.D.

SUBJECT: Addendum to CAS Business Meeting Agenda of November 3, 1972

The attached material from the Quality of Care Committee is being added to the agenda. The recent enactment of HR1, with the requirement that regional, professional service review organizations be established, makes the issue of engagement by academic medical centers in quality of care review of great importance. Dr. Weiss will report on the Committee's deliberations during the CAS Business Meeting.

AGS:cc

Attachment

COPIES TO:

INTERIM REPORT AND MINUTES (SEPT. 28-29, 1972)
SUBCOMMITTEE ON QUALITY OF CARE

At its meeting in Phoenix, on April 23, 1972 the Council of Deans of the AAMC passed and referred the following resolution to the Health Services Advisory Committee:

> "The Council of Deans recommends that the AAMC assume a leadership role in bringing together appropriate organizations for the purpose of developing standards and priorities by which the quality of health care services may be assessed, and for the purpose of assessing the appropriate role of the academic medical centers in the delivery of health care, especially in relation to any future national health insurance program."

A Subcommittee on Quality of Care, chaired by Dr. Robert Weiss of Harvard Medical School, was appointed by Dr. Robert Heyssel, Chairman of the Health Services Advisory Committee, to review the state-of-the-art in quality-of-care assessment and to submit recommendations to the Council of Deans, Council of Academic Societies and Council of Teaching Hospitals on the appropriate role of the academic medical center in the evaluation and assurance of quality health care. Members of the subcommittee are: Robert J. Weiss, M.D., Harvard Medical School; David R. Challoner, M.D., Indiana University Medical Center; Richard L. Meiling, M.D., the Ohio State University; and John H. Westerman, University of Minnesota Hospitals.

On Thursday, September 28, and Friday, September 29, the Subcommittee met with:

Dr. Philip Caper, Senate Subcommittee on Health

Dr. Paul Ellwood, American Rehabilitation Foundation

Dr. David Kessner, Institute of Medicine

Dr. Paul Sanazaro and Dr. Robert Brook, DHEW

Dr. Sam Asper and Mr. William Sale, American Hospital Association

The committee attempted to develop an understanding of the legislative thrust of Title IV of the Kennedy HMO bill as well as the various methodologies that are currently employed in quality assessment.

Various methodologies proposed

A. The Institute of Medicine has been conducting a study to evaluate, on a limited scale, the quality of health care received by specific population groups in the District of Columbia. Borrowing the concept of using radioactive tracers to study how a body organ handles a critical substance such as iodide, specific health problems were chosen to be "tracers" that would lend themselves to pinpointing the strengths and weaknesses of a particular medical practice setting or health care system. The manner in which the physician or health team routinely administers care for a set of common well-defined ailments could be an indicator of the general quality of care and the efficacy of the system delivering that care.

B. Dr. Sanazaro described the federal government's efforts in the area of quality assurance, specifically the Experimental Medical Care Review Organizations (EMCRO) and the Prototypal Professional Services Review Organizations (PPSRO). Since early 1971 HSMHA

has funded a total of 10 EMCROs, eight of which are now operational and two are in the process of developing their programs. With the exception of one EMCRO in which there is some participation by faculty of a medical school, the rest are sponsored by medical societies or medical care foundations. Generally academic medical centers have not been involved in this program. (See Appendix for a list of those organizations that have become involved with EMCROs that are either in the operational or developmental phase.)

EMCROs that have been funded have developed sets of criteria for diagnosis and treatment procedures for specific disease entities against which the actual pattern of health care is measured. Dr. Sanazaro indicated that funds will be available to set up additional EMCROs next year.

The PPSRO, to be established at the state level, is another experimental quality control mechanism that HSMHA would like to explore. The federal government will provide monetary incentives and technical assistance for establishing PPSROs to those organizations that offer evidence of commitment to developing and implementing a quality assurance program. Validation studies will be conducted to assess the quality of care in various parts of the country to determine if differences in care result in differences in paient outcome.

C. The Quality Assurance Program of the American Hospital Association provides guidelines and methodology for incorporating quality care into the hospital setting. Using both utilization review and the medical audit, the proposed program consists of four parts: 1) criteria development; 2) description of the actual practice;

3) evaluation, i.e. how does the actual practice compare with the established criteria; 4) corrective action and 5) reassessment, i.e. after corrective action has been taken, does actual practice meet the established criteria?

D. H.R. 1 provides for the establishment of Professional Standards Review Organizations (PSRO) consisting of substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and on-going review of services covered under the medicare and medicaid programs. The PSRO would be responsible for assuring that services were (1) medically necessary and (2) provided in accordance with professional standards. The provision is designed to assure proper utilization of care and services provided in medicare and medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area. The provision requires recognition of and use by the PSRO of utilization review committees in hospitals and medical organizations to the extent determined effective.

(1) Until January 1, 1976, the Secretary of HEW would be able to make an agreement only with a qualified organization which represents a substantial proportion of the physicians in the geographical area designated by the Secretary.

(2) A professional standards review organization would not be required to review other than institutional care and services unless such organization chooses to include the review of other services and the Secretary agrees.

(3) Until January 1, 1976, at the request of 10 percent or more of the practicing physicians in a geographical area designated by the Secretary, the Secretary would be required to poll the practicing physicians in the area as to whether or not an organization of physicians which has requested to conclude an agreement with the Secretary to establish a professional standards review organization in that area substantially represents the practicing physicians in that area.

If more than 50 percent of the practicing physicians in the area responding to the poll indicate that the organization does not substantially represent the practicing physicians in the area, the Secretary could not enter into an agreement with that organization.

Based upon its meeting with congressional and administrative spokesmen, together with individuals who are leaders in the rapidly expanding but little tested field of quality-of-care assessment, the subcommittee was, on the one hand, convinced of the real potential in this field, but on the other hand, was anxious about the admitted lack of definition of quality. At the same time, pilot programs, national in scope and funded by federal, state and private agencies add to the confusion and imprecision of current assessment technology. The premature adoption of these measures may lock academic health centers into a system which would seriously affect teaching and the delivery of health care.

In the past, the academic health centers have dealt with quality determination of the basis of the excellence and prestige of the institution

and the accumulated credentials of its faculty. These might be described as a heavy reliance on "input" measures while little attention has been focused on "process" and "outcome" measurement, areas that are less well understood and defined.

These impressions, however, have not slowed down legislative action to create programs to promulgate and implement standards, on the basis of controlling costs and/or improving quality. The power of the government being the largest single source of health care dollars has fairly serious implications for the promulgation of these standards, especially if the standards adopted are only those developed by the current private practice sector.

Subcommittee discussion and recommendations

From the preceding description of the forces at play, we believe that we in the academic health centers are not sufficiently involved in the development of health care standards and quality control research that will have considerable impact upon the practice of medicine within the academic health centers as well as in the rest of the health delivery system.

Although the academic health center in the past has not had responsibility for the practice of medicine after a student completes his medical training, the subcommittee believes that a new dimension of professional responsibility is now upon us. The ways in which we practice intra-institutional medicine will eventually have to submit to the same standards of quality found in our medical research. Our belief is that since the student will in any case undergo professional scrutiny and some sort of peer review and quality control of practice when he leaves the institution, he should see teaching physicians' involvement in quality-of-care assessment as part of

their teaching role. If the academic institutions do not involve themselves in the research and application of quality control standards which are appropriate to the academic health centers, we believe that they will then be forced to accept standards which are not appropriate for themselves. Regardless of when national health insurance becomes a reality, the concern for quality is an immediate one.

The subcommittee therefore believes that medical education and services should begin developing mechanisms for assuring quality. Quality assessment should be inculcated in the student while enrolled in the medical school as well as in the related affiliated institutions so that there is concern for quality in every setting of the student's education and training.

The subcommittee believes that this question of the development of quality standards is not restricted to the Council of Deans, but has obvious broad implications for the Council of Teaching Hospitals and the Council of Academic Societies. For this reason, it makes the following recommendation in the spirit that the issue is pan-AAMC rather than restricted to any one Council.

The subcommittee recommends that the AAMC undertake a 4-point program:

1. Assist in the development of prototype quality assurance programs in selected academic health centers.
2. Encourage all academic health centers to begin a program of education of staff and faculty in the current research and direction of quality control programs as they apply to health delivery.
3. Encourage establishment of training grants, scholarships, loans and stipends for professionals to be trained in the quality area.

4. Seek legislative support for the creation of academic health center PSROs as regional PSROs develop.

APPENDIX

Experimental Medical Care Review Organizations (EMCRO)
Funded by the Health Services and Mental Health Administration

1. Mississippi State Medical Association (statewide) $307,000
2. Utah Professional Review Organization (statewide) $679,000
3. Albemarle County Medical Society, Charlottesville, Virginia (6 counties) $201,000 (has some University of Virginia medical faculty participation)
4. Maine Medical Association (statewide) $50,000 developmental funds
5. Iowa Foundation for Medical Care (statewide) $65,000 developmental funds
6. Medical Association of Georgia (statewide) $341,000
7. Multnomah Foundation for Medical Care, Portland, Oregon (1 county) $243,000
8. New Mexico Foundation for Medical Care (statewide) $203,000
9. Hawaii Medical Association (statewide) $443,000
10. Sacramento Foundation for Medical Care (4-5 counties) $283,000

The following summaries of EMCRO projects represent information compiled several months ago and may not reflect the current status of these projects.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

CAS BRIEFS

BUSINESS MEETING
COUNCIL OF ACADEMIC SOCIETIES

December 5, 1972 NO. 13

THE ANNUAL Business Meeting of the Council of Academic Societies was held November 3, 1972 at the Fontainebleau Hotel in Miami Beach, Florida. Dr. Sam L. Clark opened the meeting by reporting on major activities of the Chairman within the last year. Dr. Clark called attention to the recently adopted policy statement of the AAMC on the Protection of Human Subjects participating in biomedical research projects. Dr. Clark emphasized the responsibility of academic health centers for ensuring that the rights of human subjects participating in biomedical investigations are protected and further indicated that it is anticipated that Congressional hearings will be held early in 1973 as a prelude to legislation in this area. Dr. Clark also called the attention of the group to the policy statement on eliminating the free-standing internship and on the physician draft which were briefly discussed.

THE FORM of faculty representation in the AAMC was again the subject of major discussion at the Business Meeting. It was the concensus of those present that the CAS should stand behind its resolution of 1971 endorsing the development of a Council of Faculties. However, the group was impressed by the apathy demonstrated on the part of faculty polled as to their interest in participating in a Council of Faculties.

DR. ROBERT Q. MARSTON, Director of the NIH and Dr. Leonard Laster of the President's Office of Science and Technology were invited to participate in a freewheeling discussion of progress in the Conquest of Cancer program, the Heart and Lung Act of 1972 and the present and future trends of the NIH and NIMH grant programs. These discussions permitted the members to more clearly appreciate the current status of the NIH and the NIMH training grants for both pre-doctoral and post-doctoral training and to understand the problems inherent in activating the Cancer and Heart programs during a period of stable NIH funding.

DR. JAMES WARREN presented to the group a discussion of recent changes in policy of the AMA Board of Trustees regarding participation of medical students in the care of patients hospitalized in teaching hospitals. Dr. Warren indicated that separation of medical student work-ups and progress notes from the basic hospital chart could present future problems and should be a topic for concern of the CAS.

DR. ROBERT WEISS presented a report on the impact of the new Medicare legislation (HR-1) on reimbursement for the delivery of health care in the teaching setting and particularly emphasized the potential impact of Professional Service Review Organizations. He urged that academic faculties assume leadership in promoting quality of care assurance in their communities.

THE COUNCIL of Academic Societies membership voted unanimously to recommend membership to the AAMC Executive Council of the following organizations:

American Academy of Neurology
Association of Orthopaedic Chairmen
Central Society for Clinical Research
American College of Psychiatrists
Biophysical Society
American College of Radiology

AFTER LENGTHY discussion, the Council of Academic Societies adopted an Annual dues increase effective January 1, 1974.

Active Membership	# of Soc.	Annual Dues	Yield
Less than 300	28	$ 500	$14,000
300; less than 1,000	10	1,000	10,000
1,000; less than 5,000	8	2,000	16,000
5,000 or more	5	3,000	15,000
TOTALS	51		$55,000

THE CAS membership elected the following members to its Administrative Board: Chairman-elect, Ronald W. Estabrook, Ph.D., and for two-year terms on the Administrative Board, Robert M. Blizzard, M.D., David R. Challoner, M.D., and Rolla B. Hill, Jr., M.D. A complete listing of the Council of Academic Societies Administrative Board for 1972-1973 is appended.

THE CAS membership voted to hold an all day Business Meeting on March 29, 1973, at the Mayflower Hotel in Washington, D.C.

Michael F. Ball, M.D.
Associate Director
Department of Academic Affairs
for Research
Office Phone: 466-5152 or 466-4669