



**AGENDA**  
**FOR**  
**COUNCIL OF ACADEMIC**  
**SOCIETIES**

DISCUSSION GROUPS  
AND  
BUSINESS MEETING

OCTOBER 26-27, 1980

Washington Hilton Hotel  
Washington, D.C.

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**  
*One Dupont Circle*  
*Washington, D.C. 20036*

AGENDA  
 COUNCIL OF ACADEMIC SOCIETIES  
 ANNUAL MEETING

October 26-27, 1980  
 Washington Hilton Hotel  
 Washington, D.C.

I.	<u>MEETING SCHEDULE</u> . . . . .	1
II.	<u>DISCUSSION GROUP MATERIALS</u> (October 26)	
	Increasing Inter-Specialty Cooperation in Graduate Medical Education . . . . . (blue).	2
	Development of Faculty Leaders for Research Careers . . . . .(green).	7
	Competitive Marketing of Medical Services and Its Potential Effect on Medical Education . . . . . (gray).	13
	New Faculty Responsibilities and Accountability for Research Activities . . . . . (orange).	19
III.	<u>BUSINESS MEETING AGENDA</u> (October 27) . . . . .	29
1:30 p.m.	Call to Order	
	"The Current Status of Clinical Investigation"	
	<i>--Jules Hirsch, M.D.      Professor and Senior Physician      Department of Human Behavior and Metabolism      Rockefeller University</i>	
A.	Consideration of Minutes of CAS Business Meeting, November 5, 1979 . . . . .	30
B.	Chairman's Report	
C.	<u>Action Items</u>	
	1. Election of Members to the 1980-81 Administrative Board . . . . .	39
	2. Election of Academic Society Members . . . . .	45
D.	<u>Discussion Items</u>	
	1. Legislation 1980 - The Past Should be Viewed as Prologue . . . . .	50
	2. Graduate Medical Education National Advisory Committee's Report . . . . .	52

Discussion Items (Continued)

- 3. Medicare's Altered Policy on Reimbursement of "Moonlighting" Residents . . . . . 66

E. Information Items

- 1. Accreditation Committees Reorganized . . . . . 69
- 2. Universal Application Form for Graduate Medical Education . . . 73
- 3. General Accounting Office Study of U.S. Citizens in Foreign Medical Schools . . . . . 75
- 4. Medical Sciences Knowledge Profile Program . . . . . 76
- 5. External Examination Review Committee . . . . . 77
- 6. Disposal of Hazardous Wastes . . . . . 78
- 7. Clinical Laboratory Regulation . . . . . 79
- 8. Section 227 . . . . . 80
- 9. Announcement of New Service Available to CAS Member Societies . . . . . 81
- 10. Future Meeting Dates . . . . . 82

MEETING SCHEDULE  
COUNCIL OF ACADEMIC SOCIETIES  
ANNUAL MEETING  
October 26-27, 1980

Sunday, October 26

1:30 - 3:00 p.m.	* CAS Forum on Faculty	Jefferson Room
3:15 - 4:00 p.m.	Plenary Session	Jefferson Room
4:00 - 5:30 p.m.	Group Discussions	
	Increasing Inter-Specialty Cooperation in Graduate Medical Education	Grant Room
	Development of Faculty Leaders for Research Careers	Independence Room
	Competitive Marketing of Medical Services and Its Potential Effect on Medical Education	Hamilton Room
	New Faculty Responsibilities and Accountability for Research Activities	Jackson Room
6:30 p.m.	Cocktails and Dinner	Golden Boeymonger Restaurant 1701 20th Street

Monday, October 27

1:30 - 5:00 p.m.	CAS Business Meeting	Jefferson Room
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\* This portion of the CAS Meeting will be a panel discussion focussing on data obtained in studies regarding the preparation, support, and present activity of academic physicians. The program is as follows:

Changes in Characteristics of Faculty

H. Paul Jolly, Ph.D.  
Director, Division of Operational Studies  
Association of American Medical Colleges

Volunteer Clinical Faculty: The Hope of the Future?

Jeremiah A. Barondess, M.D.  
Clinical Professor of Medicine  
Cornell University Medical College

The Academic Careers of Physicians

Charles R. Sherman, Ph.D.  
Project Director, Study of Biomedical Researchers  
Association of American Medical Colleges

## INTER-SPECIALTY COOPERATION IN GRADUATE MEDICAL EDUCATION

A discussion of inter-specialty cooperation in graduate medical education could be wide ranging and philosophical. Residents' education surely is better in settings where they learn to cooperate with residents in all specialties. However, cooperation between specialties in graduate medical education is often disrupted by parochial interests. In order to focus the discussion, three areas which are specifically mentioned in the revision of the General Requirements for Graduate Medical Education, which will soon be implemented, have been selected. All three have the potential for promoting either cooperation or discord between specialties.

### Complementary Education and Resource Allocation

Programs in graduate medical education have traditionally been considered the autonomous responsibility of each clinical discipline. At the national level, certification requirements established by boards comprised of specialists in each discipline, determine the characteristics of the education residents must complete and the exams they must pass to be certified. At the local level, program directors are expected to mount programs consistent with board requirements as specified by the residency review committees and to assume responsibility for determining that residents have the requisite competencies for certification in their discipline.

To the casual observer it would appear that each clinical discipline can provide the education needed by its residents in isolation from all other disciplines, but the realities are quite the opposite. Table I provides an analysis of the requirements for complementary education in other disciplines as set forth by the specialty boards in the 1980 edition of the Directory of Residency Training Programs. Only four disciplines do not require a resident to have any education in other disciplines. Nineteen require residents to have some education in another discipline in partial fulfillment of their educational requirements. Family practice is unique in that, while requiring education in the clinical disciplines noted, the board does not require that residents be educated in programs accredited by another residency review committee. All others require that complementary education, if not under the aegis of the program director, be in programs approved by another residency review committee. Of the four disciplines which do not require residents to have education in another discipline, surgery absolutely requires that the institution have at least an approved program in a primary care discipline and internal medicine's special requirements state that programs in other disciplines should be present.

These requirements for complementary education are the source of considerable stress at both the national and local levels. At the national level, the specialty boards requiring a first graduate year of clinical education in another discipline have pressed for a return of the equivalent of the rotating internship. The response to this is a proposal by the LCGME to permit the development of a "transitional" first graduate year under the supervision of an institutional committee in hospitals having two or more accredited residency programs. At the local level, directors of programs in disciplines requiring complementary education frequently have difficulty negotiating with other program directors for educational opportunities for their residents in approved programs.

Reducing stress and solving the problems posed by the dependence of one discipline upon another ultimately comes down to how resources are to be generated and allo-

cated at the local level. The introduction of the transitional year will not necessarily solve the problem. Institutions not now sponsoring graduate medical education programs will not be able to sponsor transitional years; thus, the equivalent of freestanding internships in hospitals not otherwise engaged in graduate medical education will not reappear. Therefore, if a formal transitional year is developed by a teaching hospital, it will require either the generation of new resources or the reallocation of available resources. This will require negotiations between program directors, as well as between hospital or medical school administrators and program directors. Should a hospital opt not to consider a transitional year, the problem of the negotiating for educational services between program directors will still be present. Lacking a spirit of cooperation and concern about the quality of all the programs sponsored by an institution, such negotiations will be both frustrating and devisive.

The new General Essentials state that there should be a description of the process by which institutional resources are distributed for educational purposes and that there should be clear evidence that the process is agreed to within the institution.

- *Can a process to distribute educational resources within an institution be devised which will promote inter-specialty cooperation and meet the educational needs of all sponsored programs?*
- *At a time when the number of available first year graduate positions is precariously close to the number of graduating students, is it reasonable to expect students to arrange complementary first graduate year educational experiences on their own?*

### Selection and Advancement Policies

Section 1.1.3 of the new General Essentials states: There should be--An operational system involving the program directors, based on institutional policies, establishing how the sponsored programs provide for:

- a) The appointment of teaching staff
- b) The selection of residents
- c) The appointment of resident positions among programs, consonant with the Residency Review Committee policies
- d) The supervision of residents
- e) The evaluation and advancement of residents
- f) The dismissal of residents whose performance is unsatisfactory
- g) The assurance of due process for residents and teaching staff

These policies should be developed after widespread consultation among the concerned parties, and should have institutional approval.

Developing a system to meet the requirements of this section will, of necessity, require inter-specialty discussion and cooperation. The intent appears to be to ensure that all the programs sponsored by an institution adhere to policies worked out and agreed to by program directors and their teaching staffs.

- *Recognizing that specific criteria may vary from discipline to discipline for subsections a, b, d, e, and f, how can an institutional system which is workable and effective be established and maintained?*
- *At the national level, can specialty boards, residency review committees, and specialty societies be of assistance in developing inter-specialty*

*agreement on criteria and promote inter-specialty cooperation?*

### Program Evaluation Policies

Section 1.1.4 of the General Requirements states: A periodic analysis of each program by representatives of the concerned departments, the residents, and the administration should be developed.

These analyses should include the appraisal of:

- a) The goals and objectives of each program
- b) The instructional plans formulated to achieve these goals
- c) The effectiveness of each program in meeting its goals
- d) The effectiveness of utilization of the resources provided

There should be documentation of these analyses and of the mechanisms to correct identified deficiencies.

This section is interpreted to mean that intramural evaluation of programs will be necessary. Effective evaluation will require that the program directors and teaching staffs of all programs sponsored by an institution cooperate in the evaluation of each program. There will have to be a willingness to criticize and a willingness to accept criticism.

- *How can a spirit of inter-specialty cooperation be attained in the critical, intramural evaluation of graduate medical education programs?*

TABLE I

## REQUIREMENTS FOR COMPLEMENTARY EDUCATION

Allergy or Immunology:	Two years of medicine or two years of pediatrics
Anesthesia:	Clinical base year of internal medicine, pediatrics, surgery, neurology, family practice, surgical specialty, or flexible program
Colon & Rectal Surgery:	Four years of surgery
Dermatology:	One year of internal medicine, pediatrics, surgery, or other discipline
Family Practice:	Training must include internal medicine, pediatrics, psychiatry, obstetrics and gynecology, surgery, community medicine*
Neurosurgery:	Six to twelve months of surgery
Nuclear Medicine:	Two years in another discipline
Obstetrics & Gynecology:	Significant period in broad clinical training (?12 months)
Ophthalmology:	Twelve months in another discipline
Orthopaedics:	One year, usually surgery
Otolaryngology:	One year surgery
Pediatric Neurology:	Two years of pediatrics
Psychiatry or Neurology:	One year of internal medicine, pediatrics, family practice, or flexible - minimum of four months of internal medicine
Physical Medicine & Rehabilitation:	Six months of medicine and surgery
Plastic Surgery: (both Dx & Rx)	Three years of surgery
Preventive Medicine:	One year of clinical education
Radiology:	One year of clinical education
Thoracic Surgery:	Certification in surgery
Urology:	Two years of surgery

\*Education in these disciplines need not be in programs accredited by another Residency Review Committee



Internal Medicine: None

Pathology: None

Pediatrics: None

Surgery: None

## DEVELOPMENT OF FACULTY LEADERS FOR RESEARCH CAREERS

The AAMC ad hoc Committee on Clinical Research Training investigated some of the factors which were responsible for attracting medical students to research careers. Some of these factors were related to student faculty interactions:

"• Additional factors cited by students as causes for the declining interest in an academic career include the lack of exposure to research through laboratory courses and informal interaction with faculty. In previous eras a student might become interested in research by repeating classical experiments in basic science or by casual laboratory interactions with faculty members. Today's medical school curricula, laboratory technology and the demands on faculty time are such that this type of faculty-student interaction is less frequent.

• The subtle disincentives that might cause medical students or residents to exclude an academic career from their career options become very tangible at the fellowship and advanced clinical trainee level. Negative attitudes conveyed by senior faculty about the problems associated with research as well as personal economic issues remain paramount on the list of disincentives. Medical students and residents may have had some perception of the disincentives to research but physicians in advanced training see at close range the uncertainties related to funding; the continuing paperwork required to obtain grant support; the heavy workload to meet teaching, administrative, patient care, and research responsibilities; and the knowledge that their colleagues in private practice are surpassing them in income."

Similar observations might be just as valid for graduate students in the basic sciences although a decline in the number of persons seeking basic biomedical research training has not yet been appreciated. In both basic and clinical sciences, however, there seems to be an even smaller number of satisfactory research career models among the faculty.

Commenting recently on the problem of recruiting clinical investigators, Dr. Jules Hirsch, of the Rockefeller University developed a theme which has significance for all areas of biomedical investigation. A part of Dr. Hirsch's recent paper presented at the Institute of Medicine is attached. In summary, Dr. Hirsch delineated three types of investigators: Type 1, the biomedical investigator who does predictable, targeted, definable research; Type 2, the opportunistic investigator who melds clinical and basic sciences in exciting, unpredictable ways; and Type 3, the "clinical, clinical" investigator who conducts uncertain research "fishing expeditions" and who occasionally makes the most illuminating discoveries of all. Type 1 researchers can be easily evaluated for support by funding agencies; consequently, they are doing relatively well. Type 2 is not doing too badly either, despite the difficulty of establishing "Fellowships for Opportunistic Investigation." But support of Type 3 investigators demands a climate in which "genius" can surface and support can be provided for talented persons rather than for predictable projects.

Again, the problem has been described in clinical science terms but it appears to have almost as much immediacy for the basic sciences, especially when the support of innovative, opportunistic researchers is contrasted against the modern tendency of funding agencies to support only "sure things" among research projects. This has led Dr. Rosalyn Yalow to call for continuing support of researchers with proven

records of scientific productivity. It has also led the Congress to suggest that the Director, NIH, have a fund for "innovative research ideas which received unfavorable priority scores!" Thus it would seem that many observers agree that Type 3 researchers must flourish to provide tomorrow's leaders in both basic and clinical sciences. The problem is how to create a climate to nurture such individuals.

The discussion group might consider—if they agree with the basic premise—which of the following might have merit:

- (1) Should new mechanisms be sought to build interdisciplinary bridges between enclaves of faculty and industry, between biomedical research faculty and other health care-related sciences or even between departments in the same institution? Are research "institutes" more or less effective in this regard?
- (2) Could established investigators (research career awardees, Heart Association Investigators, etc.) provide the necessary role models?
- (3) Should new, different or additional rewards such as "free" time, prestigious titles or general support be provided to selected researchers in recognition of their "leadership"?
- (4) Should support be provided to researchers with proven records—including that in innovative research—rather than for project support?
- (5) What lessons can be learned from the early 1950's that would aid the development in the 1980's of future leaders?

Excerpted from "Clinical Investigation: An Effort at Definition and Classification" by Jules Hirsch, M.D.

Advantages of Each Type:

Type 1, The Biomedical Model of Clinical Investigation. This is targeted, definable research. One can make estimates of the expense and the duration of investigation and it is clear when the goal has been reached. This is an ideal type of research for evaluation by funding agencies. In general, the limitations are that findings from this type of research can become increasingly removed from the actual problems faced by man.

At least two types of examples come to mind:

A. Drugs can be created or techniques invented for the prevention or eradication of certain infections. Yet, it may be that the major cause of such infections is food and water contamination. A "technological fix" of the problem by drug prophylaxis or treatment brings with it less attention to the purity of water and food supply and a much less esthetically satisfying way of life, yet with freedom from the specific illness, as seen by the biomedical scientist.

B. Another problem with Type 1 clinical investigation is the unforeseen disaster that may occur when therapy moves from the experimental animals to man. There is often startling species difference such that treatments vary widely in their effect. This is particularly true in man

since he is either unique in having a variety of affective states and specific emotional problems, or at least is unique in being able to verbalize and complain about such problems. Thus, an excellent drug for the treatment of hypertension or another drug for the eradication of rashes, all coming from basic studies might be spectacularly effective, but could lead to deep depression, impotence, ghoulish nightmares, an immense craving for alcohol, or many kinds of other symptoms, that could never be observed even in closely related primates. The cost-benefit ratio may be calculated in favor of treatment when major investment of time and money are part of the calculation.

Type 2, Opportunistic Clinical Investigation. This is an exciting way to approach problems; it necessitates close collaboration. It requires physicians to be well informed about basic science and the basic scientist to have some knowledge of the clinical implications of his work. It is a little more difficult to provide research support than in Type 1 research since it is not quite so clear where the studies will go. This kind of research is more of a gamble than Type 1. Also, it is difficult to have professionalization in the sense of establishing a Fellowship for Opportunistic Clinical Investigation. Role models of such investigators appear only sporadically on the medical scene.

Type 3, Clinical, Clinical Investigation. This is the most uncertain of all. It has been described as a

"fishing expedition." It is extraordinarily difficult to fund such investigation since funding has to be done almost exclusively by trust of the investigators. The investigators are not likely to provide protocols which clearly chart the tools to be used nor the routes to be followed in finding answers to their clinical questions. But when Type III works well, the investigators become superb role models for investigative medicine and new vistas of science undreamt by Types 1 and 2 investigation become visible. As is always the case, one cannot mandate genius, one can only create circumstances in which, talent is allowed to flourish. Type 3 clinical investigation must deal with this problem.

All of the above analyses utilize what might be called the "reductionist" approach to clinical investigation, It is assumed that by and large there is an historical progression such that problems begun under Type 3 investigation will ultimately progress to Types 2 and 1. Increasingly, one wonders whether certain integrative type disciplines particularly in behavioral science, (e.g. the Biopsychosocial Model of George Engel) may not be needed, in which Type 3 investigation reverses the usual reductionist trend. Drawing heavily from 1 and 2, clinical research of the Type 3 mode makes basic science findings meaningful, findings which otherwise would languish in textbooks of biochemical genetics or cell biology.

I would suppose that if one examines the present status of clinical investigation in the United States one would find that Type 1 is doing well, except for some governmental or legislative interferences which may make it overly cumbersome. Type 2 is not doing too badly either, but Type 3 is disappearing from the scene. If one were to decide that Type 3 is important, instrumentalities for bringing it into sharper focus and permitting it to grow would be a difficult but rewarding exercise. This would create clinical environments for those who have very special investigative questions and wish to develop unorthodox approaches to their solutions.

## COMPETITIVE MARKETING OF MEDICAL SERVICES AND ITS POTENTIAL EFFECT ON MEDICAL EDUCATION

Fundamental changes in the way health insurance and services are selected and purchased are increasingly being advocated by many health economists, business groups, and legislators as a means to stimulate cost consciousness among providers (hospitals and physicians) and consumers (individuals enrolling in health plans and patients seeking care). These proposals, which have been commonly referred to as the "competitive" approach to cost containment, often call for changes in tax laws and requirements for employers to offer multiple health plan choices to their employees. Some proposals would begin to abolish reimbursement, utilization, and planning regulations presently imposed by the federal government.

The expected result of legislation encouraging competition is that individuals and health insurance plans on behalf of their beneficiaries will look much more carefully at hospital costs and physicians fees when purchasing or contracting for health care services. In turn, those providing the services -- hospitals, HMOs, physicians -- will compete to provide their services at the lowest possible cost. Although quality of care, access, and other factors would influence consumer choice, it is presumed that price would be the primary consideration and that cost-saving would be the primary benefit.

The most obvious concern for teaching hospitals is that their costs are generally higher than those of non-teaching hospitals. Many of the high costs of teaching hospitals may be explained by such factors as the presence of educational programs, technology development and testing, patient case mix, and charity care. Presently, these activities are funded by patient care revenues, either directly or through cross subsidization. Under competitive pricing, individual consumers and third parties, HMOs, and IPAs, negotiating on their behalf may be unwilling to pay the cost of programs which may not be of any immediate, personal benefit. If this situation occurred, the teaching hospitals may be placed at a distinct disadvantage. Some of the services they now perform and products they produce may be jeopardized. On the other hand, depending on how a free market system is structured, the teaching hospital may be very competitive in some areas. In fact, if given a choice between competition and regulation, many teaching hospitals may argue on the side of competition.

The AAMC has appointed an Ad Hoc Committee to assess the potential impact of competition on teaching hospitals. In addition, John Colloton, Director of the University of Iowa Hospitals and Clinics, recently testified on behalf of the Association before the Senate Finance Subcommittee on Health on this issue. The following five pages are taken from his oral remarks.



REMARKS TAKEN FROM AAMC TESTIMONY BEFORE  
SENATE FINANCE HEALTH SUBCOMMITTEE

Underlying the competitive models being proposed is the assumption that hospitals provide a relatively standardized product which is identifiable in terms of costs and quality. This assumption raises several issues for teaching hospitals which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities result in higher costs, presently financed through patient care revenues, competitive pricing resulting from the proposed legislation could jeopardize the future ability of teaching hospitals to meet these multiple responsibilities.

There are four specific contributions of teaching hospitals which we would like to call to your attention, namely: medical education, research, new technology testing and tertiary care, quality referral care, and large scale charity care.

Medical Education

As you know, teaching hospitals are the setting for the vast majority of the clinical training of physicians at both the undergraduate and graduate medical education levels. In this context, it should be recognized that:

- Medical school enrollment has more than doubled in the past two decades and there has been a corresponding two-fold increase in the number of hospitals affiliated with medical schools.
- With virtually all medical school graduates now participating in at least three years of residency training, graduate medical education has also experienced dramatic increases. Over 80% of all residency positions are sponsored by the 418 members of the Council of Teaching Hospitals.
- New medical schools as well as established schools have, in recent years, sought broadened affiliations with community hospitals to

accommodate increased and varied educational needs.

There are substantial costs associated with a hospital's participation in medical education. Resident stipends and benefits alone now total over one billion dollars annually. These educational costs are presently recognized as necessary and legitimately reimbursable by third parties, including the Federal government. Competitive pricing could discourage insurers from purchasing care from providers whose educational and research costs make premiums uncompetitive. Competitive pricing could also encourage teaching hospitals to restrict their medical education activities.

#### Research, Technology Testing and Tertiary Care

A second general area of commitment by teaching hospitals is research, technology development and tertiary care. Teaching hospitals have served as a setting where clinical research is translated into medical practice and thereafter disseminated to community physicians and other providers. Often teaching hospitals accept medical and technological innovation as a mission, in spite of the cost implications involved. Competition among insurers and among providers may well jeopardize the continuing ability of teaching hospitals to meet this role in advancing medical research and new technology, and thereby improve the health services available to the nation as a whole.

Related to a commitment to research and technology is the provision of regional tertiary care services to seriously ill patients. This commitment may be illustrated by the fact that members of the Council of Teaching Hospitals constitute only five percent of all non-federal short-term hospitals, but:

- have over half of all the burn care units of our nation;

- supply 44% of all organ bank services;
- provide 40% of the open heart surgical services; and
- are the locations for over one third of the nation's newborn intensive care units.

These services are of unquestionable social value, but it is unclear how patients needing these services will have access to them under a competitive scheme. There are no assurances that insurers and HMO's, which contract with community hospitals, would be willing to establish adequate referral arrangements with high cost tertiary care centers to avail their beneficiaries of these specialty services.

#### Quality of Referral Care

The reluctance to establish referral arrangements with tertiary care centers has significant implications for the quality of patient care. Traditionally, physicians have been trained to provide the very best care available to their patients. Given present health insurance coverage, the physician has been able to concentrate on securing the optimal prescribed treatment for each patient, with less emphasis on the cost of the treatment. It is possible that competition may move us too far in the opposite direction. Accordingly, we must seek assurances that competition will not create economic disincentives to provide an adequate level and quality of services for patients afflicted with complex disease.

Another quality of care issue relates to consumer knowledge. Studies have repeatedly found that the quality of care can vary dramatically depending on the hospital. Despite the results of these studies, it remains difficult to translate the findings into quantitative criteria that can be widely understood

by the average consumer. Thus, when a choice is made among health benefit plans, the premium costs of the various plans, which are explicitly stated, may receive disproportionate consideration because quality is a relatively little understood factor. It is conceivable that a number of plans may develop that are competitively priced, but without provisions facilitating access to patient care of an acceptable level of quality.

#### Provision of Charity Care

Many teaching hospitals, particularly in urban areas, provide large amounts of service to the poor and near-poor of their communities. This care includes not only inpatient services but ambulatory care on a large scale. In order to remain financially viable, while providing charity care at no charge or below cost, teaching hospitals have historically priced their services so that the patients paying full charges pay, not only for themselves, but also help to underwrite the costs of charity care. In a price competitive marketplace, large scale buyers and third parties most likely will be unwilling to subsidize care for such charity patients. Thus, teaching hospitals may have to restrict the availability of charity services and/or obtain governmental or other subsidies for patients unable to pay for their care.

#### Case-Mix Differentials

Commitment to the activities I have mentioned -- medical education, research, quality tertiary care, and charity care -- create financial demands on teaching hospitals that are not present in non-teaching settings. Even if special funds could be set aside for these activities, which would be extremely difficult to

do, most teaching hospitals will likely still have higher average costs due to the patient case mix they treat. Teaching hospitals admit more seriously ill patients which require not only more complex ancillary services, but more intensive nursing and bedside care. As a consequence, the prices of teaching hospitals reflect a higher average cost per patient than those prevailing in community hospitals which treat a less intensely ill patient population. In a price competitive market, insurers may be reluctant to purchase care for their subscribers at teaching hospitals recognizing that the average pure patient care costs in the tertiary setting will exceed that prevailing in community hospitals due to case-mix differentials.

#### Summary

A great deal of conscious thought has been given by the sponsors of S.1968 to how tax laws might be modified to encourage prudent, cost-conscious decisions by consumers when they enroll in health insurance, and at the time they purchase health care services. There does not, however, appear to be an equal amount of thought being given to the long-term consequences and secondary effects of competition on certain features of our health care system. No one has clearly articulated the limits of competition or the impact of competition on various types of providers and the actual delivery of health services. The AAMC hopes that these issues will be carefully studied before any legislative initiatives are broadly endorsed.

CAS BUSINESS MEETING AGENDA

MONDAY, OCTOBER 27, 1980  
1:30 - 5:30 P.M.  
JEFFERSON ROOM  
WASHINGTON HILTON HOTEL

MINUTES  
COUNCIL OF ACADEMIC SOCIETIES  
BUSINESS MEETING

November 5, 1979

Washington Hilton Hotel  
Washington, D.C.

I. Call to Order

The meeting was called to order at 1:30 p.m. Dr. Thomas K. Oliver, Jr., Chairman presided. Sixty-three individuals, representing 57 of the 67 member societies were present.

II. Approval of Minutes

The minutes of the Council of Academic Societies Business Meeting, held on October 23, 1978, were approved as submitted.

III. President's Report

Dr. John A. D. Cooper, President of AAMC, provided a report to the Council on issues with which the Association dealt during the past year. He outlined the current status of health manpower legislative proposals in terms of the preliminary assumptions being used by the Administration, the House, and the Senate in drafting their respective bills to renew the Health Manpower Act. Dr. Cooper also reviewed the status of housestaff unionization legislation and related litigation and Sections 223 and 227 of the Social Security Act. He briefed the Council on the developments surrounding AMA withdrawal from the Liaison Committee on Continuing Medical Education and outlined current budget and staffing plans to provide for the continuing operation of LCCME.

Dr. Cooper expressed his appreciation for the increasingly important role CAS is fulfilling within the AAMC and urged Council members to continue to keep abreast of the growing number of national issues which directly affect faculty.

IV. Chairman's Report - Dr. Thomas Oliver

The full text of the Chairman's Report is attached to these minutes as Addendum 1.

V. Action Items

A. New Membership Applications

In accordance with the established procedures, election to membership in AAMC of Academic Society Members is upon recommendation by the Council of Academic Societies to the Executive Council and by majority vote in the Assembly. It was the recommendation of the CAS Administrative Board that the following applications for membership be approved by the full Council:

American Academy of Child Psychiatry  
Association of Program Directors in Internal Medicine  
Society for Health and Human Values

ACTION: The above applications for membership were unanimously approved.

NOTE: On November 6, 1979, by action of the AAMC Assembly, these societies were elected to AAMC Membership, increasing to 70 the number of societies in the CAS.

B. Election of Members to the 1979-80 Administrative Board

ACTION: The Council elected the following to serve on the CAS Administrative Board to take office at the conclusion of the CAS Business Meeting:

Chairman-Elect

Daniel X. Freedman, M.D., Representative, American Association of Chairmen of Departments of Psychiatry (Chairman, Department of Psychiatry, University of Chicago)

For Administrative Board, from the Basic Sciences

To serve one year, completing the term of Dr. Frank Young:

Robert L. Hill, Ph.D., Representative, Association of Medical School Departments of Biochemistry (Associate Professor, Department of Biochemistry, Duke University)

To serve a three-year term:

Lowell Greenbaum, Ph.D., Representative, American Society for Pharmacology and Experimental Therapeutics (Chairman, Department of Pharmacology, Medical College of Georgia)

For Administrative Board, from the Clinical Sciences (for three years);

Joseph E. Johnson, III, M.D., Representative, Association of Professors of Medicine (Chairman, Department of Medicine, Bowman Gray)

Frank C. Wilson, Jr., M.D., Representative, American Academy of Orthopaedic Surgeons (Professor, Department of Orthopaedic Surgery, University of North Carolina)

Carmino D. Clemente, Ph.D., Representative, American Association of Anatomists (Director, Erain Research Institute, UCLA) was installed as Chairman at the conclusion of the meeting.

VI. Discussion Items

A. Reports from Discussion Groups

Dr. Oliver asked each of the leaders of the discussion groups which had been held the previous day to provide a report to the full Council.

1. Research Resource Strategies. Dr. Carmino Clemente provided a summary of the Research Resource Strategies session. He reported that



the group discussed in some depth ways for assuring continuing and stable support for research and particularly for basic, untargeted research. Among recommendations the group developed in this regard were: 1) the typical length of grant support must be lengthened and 2) scientists must be convinced that restrained and stable research support is in their best interest in the long run because of the devastating effect of large, short-term increases which result in the "peaks and valleys" phenomenon. The group also spent a considerable amount of time discussing the increasingly poor condition of laboratory facilities and the proliferation of outmoded and deteriorating equipment. Participants recommended that AAMC conduct a survey to document the need for facility remodeling and construction and for equipment replacement. After the true status of the national requirements in these areas is ascertained, AAMC and other groups interested in research support might explore mechanisms for including equipment and facility depreciation in research grants. The discussion group also stressed the need for generating new sources of research support and for educating faculty about how basic research support (such as BSRGs) is actually being used in their institutions. Dr. Clemente reported that the discussion group had also reviewed the Health Science Promotion Act of 1979 (S.988) and had concluded that it was not a very promising piece of legislation in terms of providing true support for the health sciences.

2. Accreditation. Dr. August Swanson reviewed the major items of discussion at the Accreditation session. He reported that the participants had reviewed the twelve principles developed by the Working Group on Accreditation of the Graduate Medical Education Task Force and had agreed with the thrust of all of them. Several editorial modifications which would change the emphasis of some of the principles had been recommended and would be passed on to the Task Force. After Dr. Swanson reviewed the discussion group's comments on each of the accreditation principles, there were several questions raised about plans for implementation of the Report and about whether the Report's emphasis on institutional responsibility was laying the groundwork for institutional accreditation. Dr. Gordon Douglas, Chairman of the Working Group, reiterated that institutional responsibility for graduate medical education and institutional accreditation are two entirely different concepts and that the Working Group was not recommending institutional accreditation. Dr. Douglas also stressed that the Working Group viewed its report as a starting point for improving the accreditation process for graduate programs and for stimulating much needed change and discussion in this area.
3. Decline in Clinical Research Manpower. Dr. Samuel Thier, Chairman of the AAMC ad hoc Committee on Clinical Research Manpower, reviewed the background and recommendations of the committee report as well as the major points raised by the Discussion Group on Clinical Research Manpower. The discussion group had concurred with the committee's assessment that the magnitude and complexity of this issue required a broad and concerted approach rather than singular efforts to change certain aspects of the problem. It was agreed that the final report should place more emphasis on the deleterious impact of isolated

efforts to increase research manpower (e.g., increasing stipend levels without increasing overall funding which would undermine successful and competitive training programs by forcing them to cut positions). The discussion group had also agreed that all involved organizations and agencies must work together to address this issue and to publicize the existence of this very serious manpower problem. The group concluded that AAMC will have to assume a coordinating role in bringing together the efforts of CAS societies, medical schools, teaching hospitals, foundations, and government to effectively reverse current trends in clinical research manpower.

4. Competency Testing. Dr. Frank Wilson outlined the topics discussed in the Competency Testing session. He reported that his group was apprised of the current activities of the Federation of State Medical Boards, including the development of FLEX I and FLEX II, as well as the efforts of the NBME to develop an instrument to measure psychomotor and interpersonal skills along with the traditional cognitive skills. Issues discussed by the group were: 1) the definition of competency, 2) ingredients of competency, 3) rationales for attempting to measure competency, and 4) how competency testing in medicine can be improved. Dr. Wilson reported that the discussion group identified several goals which would advance the area of competency testing: developing a clear definition of competency for all specialty areas; conducting a major educational effort to increase awareness of the pitfalls of measuring competency; developing adequate means of measuring psychomotor and interpersonal skills; and urging institutions to assume greater responsibility for competency testing. Dr. Wilson concluded by stating that the discussion session had been very productive and interesting and he urged the Council to take further initiatives in this area in the future.
5. Specialty Distribution. Dr. Theodore Cooper, Chairman of the Working Group on Specialty Distribution, provided a summary of the issues discussed in that session. He reported that the participants had agreed with the major thrust of the Working Group's report. In particular, there was agreement that national groups should not dictate specific numbers. There was also concern expressed about using accreditation mechanisms to limit physician supply. Dr. Cooper also reported that the discussion group had reviewed at some length the recommendation that graduate medical education programs in family practice, internal medicine, and pediatrics should be expanded. The discussion group felt that there is no data to show what degree of expansion is required beyond what has already occurred in these training programs. Dr. Cooper indicated he would report back to the Task Force the group's suggestion that the recommendation be changed to state that these programs should be maintained at present levels.

Following Dr. Cooper's summary of the discussion group on Specialty Distribution, Dr. Albert R. Williams, Senior Economist at the Rand Corporation, provided a report on the results of a recent Rand study of the geographic diffusion of physicians over the past seven years. Essentially, the study shows that there has been a large increase of

board-certified physicians practicing in non-metropolitan areas and that physician/population ratios in these areas have improved substantially. Several CAS representatives expressed a great interest in this data pointing out that self-regulation by the profession of geographic distribution may preempt federal regulation and intrusion in this area.

B. Clinical Laboratory Improvement Act

Ms. Plumb provided a brief report on the status of current clinical laboratory bills pending in both the House and Senate. She reviewed the numerous problems posed by these bills for laboratories in academic medical centers and stated that the Council would be kept informed of the status of CLIA legislation.

VII. Guest Speaker

Gerald L. Klerman, M.D., Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, spoke to CAS on "The AAMC-ADAMHA Interface."

VIII. Adjournment

It was announced that the tentative dates for the CAS Interim Meeting for 1980 were March 18-19 in Washington, D.C.

The meeting was adjourned at 6:00 p.m.

REPORT OF THE CHAIRMAN  
COUNCIL OF ACADEMIC SOCIETIES\*

By

Thomas K. Oliver, Jr., M.D.  
Chairman, 1978-79

It has been an honor to be selected by you to be the Chairman for this past year, especially since this is the International Year of the Child; I believe I am the first Pediatrician to have been Chairman of the CAS; thus it was a particular honor and one which I think may or may not have been coincidental. The scenario as I see it goes something like this: John Cooper, realizing that he was stuck with me, decides to jazz things up and calls the World Health Organization in Geneva and says, "Let's do something--how about an International Year of the Child?"

CAS is now 12 years old and in terms of child development, it would now seem that the behavior of the organization is reasonably well set. Changes may still occur with the passage of time and those of us who have or have had teenage children know that the behavior can change both for the good and the bad, but I will leave it to subsequent chairmen to describe the teens. To carry the developmental theme a bit further let me remind you that the parent or parents of our academic societies is the CAS, and it has been remarkably fertile. There are seventy children. Each child is different; each has his different demands; and as with all children, each seeks dependence while demanding independence. All of this makes the CAS a much more difficult family to manage than the other Councils because the constituency is so remarkably diverse.

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\*Presented 5 November 1979 at the Annual Business Meeting of the Council of Academic Societies, held in conjunction with the AAMC Annual Meeting, Washington Hilton Hotel, Washington, D.C.

That is not to say that there is agreement among all deans and all heads of teaching hospitals but they have much more in common with one another than our seventy academic societies. With this in mind, it has been the position of the CAS and the AAMC not to give one child more attention than another, which in translation means that the parochial needs of the individual societies should not be addressed. A possible exception to this policy has been the AAMC's very strong interest in the Veteran's Administration Program, because the VA program is essential to medical schools. However, I would remind you that it does nothing for the support of programs in Obstetrics/Gynecology or Pediatrics. In the past, the AAMC has been rather unresponsive in support of these programs. Recently, however, the record has changed impressively. The AAMC, through the CAS, has taken a strong position to support education and research in maternal and child health care in its response to the Select Panel for the Promotion of Child Health which is chaired by Lisbeth Schorr. Occasionally it makes good sense for the CAS to support one or more of the constituent societies. The position taken by the AAMC on Section 227 strongly supporting hospital-based physicians is another good example.

In the remaining minutes I would like to focus on the Report of the AAMC Task Force on Graduate Medical Education chaired by Jack Myers, and highlight a few of the recommendations. First of all the Report emphasizes that Graduate Medical Education is an essential phase of the formal medical education of physicians and its principal goals are to prepare proficient practitioners of medicine and to equip them for continued professional development. These goals are the standards against which the quality of graduate medical education should be measured. As I mentioned in my keynote address at the CAS Interim meeting last Spring it is the clear thrust of the

Task Force to require institutions to take a greater responsibility is assuring the quality of their programs in graduate medical education.

The Task Force has made several recommendations concerning the transitional year that are of considerable interest: 1) all graduate medical education should be under the aegis of the NRMP--that there be a single matching program for all graduates, 2) letters from the Dean and others about students are not to be sent prior to the first of October of the fourth year so that there can be some clinical experience in the fourth year as well as the third year on which to make a judgment, 3) the time to submit the match list to NRMP will be extended until early February, 4) the transitional year should begin on or about the 24th of June with an orientation program, 5) finally, the delineation of only two forms of graduate education in the transitional year--the traditional categorical programs and the mixed programs--simplifies that process to a considerable degree.

It is in the area of accreditation that the Task Force has given its most powerful recommendations and I wish to express my views regarding two or three of these. First of all, the Task Force recommends that a specialty board should not be the sole sponsor of a Residency Review Committee and that a member of the LCGME, such as the AMA, should not be a sponsor of any RRC. I fully support this recommendation because otherwise it results in double representation. The Task Force makes a strong case for reorganizing and retiming the site survey and improving the quality of the site survey, using as a model the self-study and the team approach to all programs in an institution much as the LCME now does. The need to improve many aspects of the site survey process is apparent to all of us involved in residency training. The LCME model is an interesting idea. The use of trained non-M.D. data gatherers coupled with competent M.D. site surveyors could vastly improve the site survey. I am not convinced that all surveys must be accomplished by specialists.

At the organizational level training programs of proven quality should be surveyed at longer intervals (similar to current LCME policy which now grants accreditation for as long as ten years). Although the staff has not organized this as yet, it surely should be possible to schedule GME review as an institutional phenomenon, again a la LCME. This seems particularly appropriate in view of the recommendation for greater institutional responsibility. Finally, the Task Force recommends a separate staffing for RRC's and the LCGME.

At present these staff functions are provided by the AMA. As a consequence the AMA plays a more dominant role in the accreditation of graduate medical education than is appropriate. The costs of accreditation should be borne by the institutions whose programs need to be accredited while the costs for developing policy should be borne equally by the parents of LCGME. At the present, the AMA bears one-half the expense of accreditation. They, not the LCGME, establish the budget. They also hire the administrative staff and select the site surveyors. They even select the stationery and it is noteworthy that on applications for residency training, site survey reports, etc., the letterhead is the Council of Medical Education of the American Medical Association, not LCGME. I believe separate staffing, separate funding and organization is absolutely essential for the accreditation of graduate medical education.

Finally I would like to thank the Administrative Board of the CAS which does much of the work of the organization, as well as the superb staff led by Gus Swanson. Gus and I have been close friends since we entered medical school together in 1945. It is rewarding to see how much he has learned from me over these years. The Board and the Staff has been enormously supportive this year and remarkably helpful. Thank you all very much.

## ELECTION OF MEMBERS TO THE 1980-81 ADMINISTRATIVE BOARD

The 1980 CAS Nominating Committee met by conference call on May 28, 1980 to develop a slate of nominees for vacant positions on the Administrative Board. The slate of nominees which resulted from that meeting is as follows:

### CHAIRMAN-ELECT

David M. Brown, M.D.  
Academy of Clinical Laboratory Physicians  
and Scientists  
Minneapolis, Minnesota

### BASIC SCIENCE POSITIONS

Robert L. Hill, Ph.D.  
Association of Medical School Departments  
of Biochemistry  
Durham, North Carolina

William F. Ganong, M.D.  
Association of Chairmen of Departments  
of Physiology  
San Francisco, California

\* Brian A. Curtis, Ph.D.  
American Physiological Society  
Peoria, Illinois

### CLINICAL SCIENCE POSITIONS

John B. Lynch, M.D.  
Educational Foundation of the American Society  
of Plastic and Reconstructive Surgeons  
Nashville, Tennessee

Curriculum Vitae forms for candidates appear on the following pages.

\* To serve on the Board for one year, completing the current term of Dr. David Brown should he be elected Chairman-Elect.



NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: David M. Brown, M.D.  
 Present Location (School): U. of Minnesota  
 CAS Society: Academy of Clinical Laboratory Physicians and Scientists  
 Undergraduate School: U. of Illinois-Chicago and U. of Illinois Urbana  
 Degree: B.S. Date 1956  
 Medical School: U. of Illinois-Chicago Year Graduated: 1960

Location and Nature of Major Graduate Training:

*Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):*  
Intern, Rotating, U. of Illinois Research & Educ. Hospitals, 1960-61

Resident, Pediatrics, U. of Minnesota Hosp. 1961-62

*Fellowship (e.g., Peds/Cardiology, Yale University, 1960-61):*  
Endocrinology & Metabolism, U. of Minnesota Hosp. 1962-65

Board Certification:

Pediatrics, 1966 ; Pediatric Nephrology, 1974; Spec. Comp. Chem. Path., 1976  
 (Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

U. of Minnesota: Dir. of Clinical Labs, '71-Present; Prof. of Pediatrics,  
'73-Present; Prof. of Lab. Med. & Pathology, '73-Present

Act. Head, Dept. of Lab. Med., '70-71; Assoc. Prof. of Peds & Lab.

Med., '70-73; Asst. Prof. of Peds & Lab. Med., '67-70

Attend. Staff, Ped. Endocrin--Wilford Hall, USAF Hosp. San Antonio, '65-67

Societies/Affiliations:

AAMC/CAS, 1976-Present, Acad. Clin. Lab. Physicians & Scientists-Pres. Elect.  
Central Soc. for Clin. Research, Endocrine Soc., Soc. for Pediatric Research,  
Amer. Assn. for Advanc. of Science, Amer. Diabetes Assn., Amer. Ped. Society,  
Lawson-Wilkins Soc. of Pediatric Endocrinology, Orthopedic Research Soc.,  
Amer. Physiolog. Soc., Amer. Soc. of Clin. Path., Amer. Soc. of Nephrology,  
Amer. Society of Pediatric Nephrology

Honors/Awards:

NIH - RCDA 1968-1973

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Robert L. Hill

Present Location (School) Duke University

CAS Society: Association of Medical Schools, Departments of Biochemistry

Undergraduate School: University of Kansas

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

University of Kansas, 1949-54, Ph.D., 1954, Biochemistry

Academic Appointments (with dates)

University of Utah, 1954-61 - Instructor to Assoc. Res. Professor

Duke University, 1961-79 - Associate Professor to Professor and Chairman

Societies/Affiliations:

American Society of Biological Chemists, Council 1969-78, Secretary  
1972-75, President, 1976.

National Academy of Sciences

Institute of Medicine

American Academy of Arts and Sciences

Honors/Awards:

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: WILLIAM F. GANONG, M.D.  
 Present Location (School) Dept. of Physiology, University of California, San Francisco  
 CAS Society: Association of Chairmen of Departments of Physiology  
 Undergraduate School: Harvard  
 Degree: A.B. Date: 1945  
 Medical School: Harvard Year Graduated: 1949

Location and Nature of Major Graduate Training:

*Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):*

Peter Bent Brigham Hospital, 1949-51

*Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):*

Medicine and Surgery, Harvard, 1952-55

Board Certification:

(Specialty/Date)

(Specialty/Date)

Academic Appointments (With Dates):

Department of Physiology, University of California, San Francisco

Assistant Professor, 1955-60

Associate Professor, 1960-64

Professor, 1964-date

Chairman, 1970-date

Societies/Affiliations: American Physiological Soc. (Pres. 1977-78); Assoc. of Chairmen of Depts. of Physiology (Pres. 1976-77); International Soc. of Neuroendocrinology (Vice-Pres. 1976-80); Endocrine Society (Chairman, Nominating Committee, 1980-81); Amer. Assoc. for the Advancement of Science; Amer. Soc. for Pharmacology and Experimental Therapeutics; Council for High Blood Pressure Research, Amer. Heart Assoc, International Brain Research Organization; Society for Neuroscience; Society for Experimental Biology and Medicine

Honors/Awards:

Various Lectureships; ACDP Award for Contributions to Physiology;

Fellow, American Society for the Advancement of Science.

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Brian Albert Curtis, Ph.D.

Present Location (School) Peoria School of Medicine, Univ of Illinois

CAS Society: American Physiological Society

Undergraduate School: University of Rochester, 1958

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

The Rockefeller Institute, 58-63, Ph.D., Physiology

Duke University, Dept. of Physiology, Post Doctoral Fellow, 63-65

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\_\_\_\_\_  
\_\_\_\_\_

Academic Appointments (with dates)

Tufts University School of Medicine, Dept of Physiology, 65-74 also  
Assistant Dean for Educational Planning, 69-73

University of Illinois, Peoria school of Medicine, Assoc.Prof of Physiology, 74-  
Assistant Dean for Undergraduate Medical Education, 74-79

\_\_\_\_\_

Societies/Affiliations:

American Physiological Society, Chr. Committee on Public Policy, Public  
Affairs rep to CAS, rep to FASEB Public Affairs Comm.

Biophysical Society, Society of General Physiologists

\_\_\_\_\_  
\_\_\_\_\_

Honors/Awards:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: John B. Lynch, M.D.  
 Present Location (School) Vanderbilt University Medical Center  
 CAS Society: American Society of Plastic & Reconstructive Surgeons  
 Undergraduate School: Vanderbilt University  
 Degree: None Date: \_\_\_\_\_  
 Medical School: University of Tennessee Year Graduated: 1952

Location and Nature of Major Graduate Training:

*Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):*

General Surgery & Plastic Surgery Training - University of Texas Medical Branch at  
Galveston 1956 - 1962

*Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):*

Board Certification:

American Board of Surgery 1962  
(Specialty/Date)

Re-certified American Board of Plastic Surgery 1978  
American Board of Plastic Surgery 1963  
(Specialty/Date)

Academic Appointments (With Dates):

Assistant Professor of Plastic Surgery - University of Texas Medical Branch 1962

Associate Professor of Surgery - University of Texas Medical Branch 1967

Professor of Surgery - University of Texas Medical Branch 1972

Professor and Chairman Department of Plastic Surgery - Vanderbilt University Medical Center  
1973

Societies/Affiliations:

American Society of Plastic & Reconstructive Surgeons; American Association of Plastic  
Surgeons; American College of Surgeons; American Surgical Association; Southern  
Surgical Association; and 22 other professional societies.

Honors/Awards: Member, Amer. Board of Plastic Surgery 1974-80; Chairman, Amer.  
Board of Plastic Surgery 1979-80; Historian and Member of Board of  
Directors Amer. Society of Plastic and Reconstructive Surgeons 1979-80; Member

Editorial Board Plastic & Reconstructive Surgery 1973-79; Member Board of Trustees  
Amer. Assoc. of Plastic Surgeons 1974-77; Chairman FDA Panel on General and Plastic  
Surgery Devices 1974-78; Consultant in Plastic Surgery to the Surgeon General,  
United States Air Force.

ELECTION OF ACADEMIC SOCIETY MEMBERS

The following academic societies are submitted for consideration for election to membership status within the AAMC:

American Association for the Surgery of Trauma  
Association of Departments of Family Medicine

Both of these societies have been recommended for membership by the CAS Administrative Board and have been forwarded to the CAS and the Assembly for approval. Their applications appear on the following pages.

MEMBERSHIP APPLICATION  
COUNCIL OF ACADEMIC SOCIETIES  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: AMERICAN ASSOCIATION FOR THE SURGERY OF TRAUMA

MAILING ADDRESS: c/o George F. Sheldon, M.D., Secretary  
Surgery Service, Ward 3A  
San Francisco General Hospital  
1001 Potrero Avenue  
San Francisco, CA 94110

PURPOSE: To cultivate, study and improve the science and art of the surgery of trauma and allied sciences.

MEMBERSHIP CRITERIA: 1) graduation from a Class A medical college  
2) establishment of a reputation as a practitioner, author, teacher or original investigator in surgery  
3) recommendation by the Board of Managers  
4) certification by specialty board & fellowship in ACS or related Royal college.

NUMBER OF MEMBERS: approx. 700

NUMBER OF FACULTY MEMBERS: n/a

DATE ORGANIZED: 1939

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

1978 revision 1. Constitution & Bylaws

1978 meeting & minutes Program & Minutes of Annual Meeting

1979 Program included

(CONTINUED NEXT PAGE)

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?

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.

George F. Sheldon  
(Completed by - please sign)  
George F. Sheldon, M.D., Secretary,  
A.A.S.T.  
11 / 12 / 79  
(Date)



MEMBERSHIP APPLICATION  
COUNCIL OF ACADEMIC SOCIETIES  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: Association of Departments of Family Medicine

MAILING ADDRESS: %Williams Myers and Quiggle  
888 17th Street, NW  
Washington, DC 20006

PURPOSE: Promote, in cooperation with educational institutions, other educational associations, government agencies, and other non-profit organizations, the common interests of department of family medicine in medical schools and teaching hospitals (or when there is no such department, a division or section in a medical school or teaching hospital having interests, functions and purposes similar to departments of family medicine) located in the United States and elsewhere, through publications, research and discussion of problems of mutual interest and concern, and to further the efficient and effective operation of departments, divisions and sections of family medicine for the benefit of faculty, students and administrators.

MEMBERSHIP CRITERIA: Regular members shall be educational institutions (which includes a medical school or teaching hospital department, division or section family medicine) which are either (a) organizations exempt from Federal income taxation under Section 115(a) of the Internal Revenue Code of 1954 or (b) organizations described in section (over)

NUMBER OF MEMBERS: approximately 70

NUMBER OF FACULTY MEMBERS: Same

DATE ORGANIZED: May 1978

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

  X  May 1978   1. Constitution & Bylaws

  x  10/25/78   2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

Members Criteria (cont): 501(c)(3) which also are not private foundations under section 509(a)(1), (2) or (3) of said Code (or the corresponding provisions of any future United States internal revenue law).

QUESTIONNAIRE FOR TAX STATUS

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

YES  NO

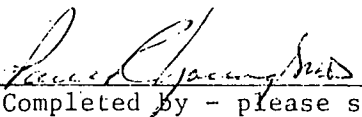
2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501(c)(3)

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

- 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)

June 4, 1979  
 (Date)

## LEGISLATION 1980 - THE PAST SHOULD BE VIEWED AS PROLOGUE

Though it has ended its regular session, the 96th Congress will return as a November "lame duck" in an unpredictable mood which should give pause to all CAS members. There are some lessons to be learned from the recent months which will be very important for this session and for next year:

- No matter who wins November 4 the 97th Congress will be a very new one and its "institutional memory" in the health area will have been largely erased. The departure of Senator Schweiker and of Representatives Tim Lee Carter and David Satterfield from their respective health Subcommittees will continue the change started two years ago by Representative Rogers. The remaining leaders, especially those in the House, are younger, more ambitious and play a very different game than those they have replaced. Names like Fogarty, Hill and Shannon have little impact on the House Subcommittee and even less on the rest of the House Members.
- Biomedical research is still a supportable commodity but its supporters are less vocal, more critical and demand more visible results. That research is still attractive is attested by the actions of both Houses to restore and even increase the biomedical research training funds deleted in the 1981 budget proposed by the President. Not only will the same number of trainees be supported as in 1980 but they will get well-deserved stipend increases. In addition, the NIH budget overall was increased slightly over the President's request in a year when most non-defense spending was curtailed.

At the same time that the Appropriation Committees were taking these actions in support of biomedical research, both House and Senate were engineering bills (S. 988 and H.R. 7036) which would limit the budget authority of NIH and its capacity to deal with the increasing fiscal stringencies of the 1980s. At the same time both bills required more accountability for research funds--the Senate through the oversight of an advisory council and the House through authorizations which would have to be renewed every three years. During its deliberations the Senate recognized that triennial re-authorizations were likely to lead to even more "disease-a-month" mischief and other problems and removed this provision. But the House members found the vision of frequent authorization hearings and public appeals for more and more disease-specific programs to be irresistibly attractive. In the last analysis, it was this quintessential political appeal which made H.R. 7036 so unbeatable.

- The two health research bills now have passed their respective houses by wide margins but have not yet been conferenced. Senator Kennedy, urged by the research community to hold fast to S.988, has stood firm against Mr. Waxman's attempts to obtain a conference and through it the triennial NIH authorizations he so desires. There are signs that a compromise will be offered. Nevertheless, the struggle is far from ended.

What are the lessons to be gained here? First, the scientific community recognized too late the harmful thrust of the Waxman bill. In spite of an unprecedented outpouring of eloquent, rational letters and personal contacts we could not convince the Congress. Second, no amount of eloquence or reason could prevail against political expedience. Third, the political process is such that the struggle, not yet over, will be significantly affected by factors having nothing to do with science--the outcome of the elections. Certainly, CAS Representatives should not be disheartened by recent events and, because "lame duck" sessions may witness even more political trade-offs than usual, we should be prepared to work hard again in the next four to six weeks.

- Finally, there is 1981. CAS Representatives have made many valuable contacts while working on the 1981 budget and health research bills over the past few months. Those contacts can, and should, be put to good use in the coming year. In the event that the health manpower and health research bills do not pass in this Congress, these bills and the renewal of research training authorities will need to be reconsidered. In addition, the following is a preliminary, and not by any means exhaustive, list of legislation which is likely to be considered in the 97th Congress:

- Programs authorized by Title III of the Public Health Service Act, such as:
  - Community Health Centers
  - Rural Health Initiative
- Maternal and Child Health Programs
- Health Maintenance Organizations
- Drug Regulation Reform
- Clinical Laboratories Improvement Act
- Medicare and Medicaid Reforms contained in H.R. 3990 and H.R. 4000 not acted upon this year
- Catastrophic Health Insurance
- Medicaid Community Care Initiatives

The potential changes in the power structure and outlook of both the Administration and the Congress will require the academic medical community to be even more energetic in explaining its role and mission.

## GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE'S REPORT

The Graduate Medical Education National Advisory Committee submitted its report to the Secretary of HHS on September 30. GMENAC was chartered by the then Secretary of HEW Matthews in 1976; and its original membership was appointed by him in the waning days of the Ford Administration. Its charge was--"to advise the Secretary on the number of physicians required in each specialty to bring supply and requirements into balance, methods to improve the geographic distribution of physicians and mechanisms to finance graduate medical education."

GMENAC's prediction of requirements for physicians in the future are based upon a complex modeling process derived from data on the prevalence of disease, estimations of the need for physicians to provide services for various conditions, estimations of the services that could be provided by other health professionals and the productivity of physicians and other health professionals. Based upon this complex modeling process, GMENAC predicts that there will be 70,000 more physicians than required by 1990; and that all but seven specialties and sub-specialties will be in over supply (see Figure 1, page 55).

Last spring the Association commented upon the modeling process being used by GMENAC and expressed its concerns that the process could not take into account the changes in physician services that will be required due to unforeseeable changes in knowledge and new technological developments. Concerns were also expressed about the heroic assumptions that the panelists had to make regarding future consumer preferences, future resources to be allocated to medical services and the future productivity of physicians.

The report contains forty recommendations (see pages 56 - 58 ). There has not been sufficient time to analyze the report thoroughly. The recommendations which may have significant impact on the medical schools and their undergraduate and graduate programs are denoted with a "●".

1. A reduction in the entering class of 1984 to a level of 10 percent less than the entering class of 1978 is recommended. Based upon the projected class size of 1982, this would mean a reduction from 18,151 to 14,833, an overall decrease of 18 percent. Such a rapid change will be difficult to accomplish since the decision to diminish the size of any school's entering class will require an assessment of the impact on the institution, the state and the region. As an example, Ohio has four state medical schools which, in 1982, are projected to enroll 606 first year students. An 18 percent reduction by 109 positions would nearly be the equivalent of the entering class size of three of the four schools. In neighboring Indiana, with only one medical school, an 18 percent reduction would mean a decrease in entering class size from 318 to 261. The table beginning on page 59 shows the estimated reductions required in each medical school.
2. GMENAC estimates that by 1983 4,100 graduates of foreign medical schools will be entering the United States yearly and recommends that this number should be severely restricted. If it cannot be, it is GMENAC's view that the enrollment in domestic medical schools should be curtailed even further. Eight supportive recommendations are particularly targeted toward reducing the number of U.S. citizens enrolling in foreign schools with the expectation that they will be accommodated in this country's health care system. These recommendations, plus the findings to be reported by the General Accounting Office from their study of six foreign medical schools, may make policymakers

more resistant to the demands of lobby groups which are seeking special privileges for U.S. citizens enrolled in foreign schools.

4. It is recommended that no specialty should be expected to increase or decrease the number of first year positions in its graduate medical programs by more than 20 percent between 1980 and 1986. Table 6 on page 65 is included in the report to show illustrative rates of entry into first year graduate positions in 1986. The inclusion of this table was heatedly debated by GMENAC members. Those opposed believe that the specificity of the entry rates cannot be justified because the predicted surpluses or shortages in each specialty are not sufficiently exact. They were fearful that even though the table is labeled "illustrative rates" the numbers will be viewed as recommended targets and attempts to implement them either through national or local policy decisions might occur even on a shorter time span than six years.
5. It is recommended that graduates should be encouraged to enter specialties predicted to be in short supply by 1990 or to enter the primary care specialties. The latter recommendation is somewhat contradictory since primary care specialties are predicted to be in excess.
14. Recommends that analyses of medical services needed in geographic regions be based upon specialty-specific functional medical service areas. This approach, rather than the usual analyses by geopolitical units, may provide more rational assessments of the geographic distribution of physicians.
24. Calls for medical students and junior residents to have a broad-based education in the generalist clinical fields. It is not clear whether GMENAC intended to support the idea generated in other quarters that all students should be required to take a broad-based clinical first graduate year.
26. Recommends that medical schools increase the diversity of their enrolled students by promoting more flexibility in admission requirements and by broadening the characteristics of the applicant pool with respect to age, sex, race, and socio-economic status. Since an economic barrier is likely to be a major impediment to diversity, the Committee's recommendation that loans and scholarships be provided to support the schools' continuing efforts to maintain diversity is welcome.
28. Recommends discontinuing capitation grants based upon enrollment increases. GMENAC is silent on the need for continued Federal participation in the support of medical education through the provision of flexible institutional support.
32. Recommends that graduate medical education should be principally financed through the normal rate structure for patient care in teaching hospitals and that the cost should be equitably borne by all payors. GMENAC goes on to call for a uniform reporting system directed toward distinguishing educational costs from patient care costs. A multi-million dollar study has been instituted by DHHS to once again attempt to separate educational costs from patient care costs in the teaching setting. The inextricable intertwining of patient care with education in teaching hospitals is not likely to be untangled by further studies or by any uniform reporting system.
34. GMENAC supports paying teaching physicians professional fees "--when their services have been identifiably discreet and necessary." This is the only

reference to the issues surrounding the implementation of Section 227 of the Medicare Amendments.

38. Recommends that the development of academic medical faculty be supported through adequate financing for their training. Approaches to financing are not specified.
39. The Committee calls for continued collaboration between health professionals and government in manpower planning and recommends that there be a successor to GMENAC on the basis that there will be a continuing need to monitor the supply of physicians and to refine and update estimations of requirements. It is stated that such a successor should be advisory and not regulatory. No mention is made of the role existing Federal agencies, such as the National Center for Health Services Research and the National Center for Health Statistics, could play in lieu of creating another advisory body.

## Ratio % of Projected Supply to Estimated Requirements-1990

	Ratio%	Requirements	Surplus (shortage)
<b>Shortages</b>			
Child Psychiatry	45%	9,000	(4,900)
Emergency Medicine	70%	13,500	(4,250)
Preventive Medicine	75%	7,300	(1,750)
General Psychiatry	80%	38,500	(8,000)
<b>Near Balance</b>			
Hematology/Oncology-Internal Medicine	90%	9,000	(700)
Dermatology	105%	6,950	400
Gastroenterology-Internal Medicine	105%	6,500	400
Osteopathic General Practice	105%	22,000	1,150
Family Practice	105%	61,300	3,100
General Internal Medicine	105%	70,250	3,550
Otolaryngology	105%	8,000	500
General Pediatrics and Subspecialties	115%	36,400	4,950
<b>Surpluses</b>			
Urology	120%	7,700	1,650
Orthopedic Surgery	135%	15,100	5,000
Ophthalmology	140%	11,600	4,700
Thoracic Surgery	140%	2,050	850
Infectious Diseases-Internal Medicine	145%	2,250	1,000
Obstetrics/Gynecology	145%	24,000	10,450
Plastic Surgery	145%	2,700	1,200
Allergy/Immunology-Internal Medicine	150%	2,050	1,000
General Surgery	150%	23,500	11,800
Nephrology-Internal Medicine	175%	2,750	2,100
Rheumatology-Internal Medicine	175%	1,700	1,300
Cardiology-Internal Medicine	190%	7,750	7,150
Endocrinology-Internal Medicine	190%	2,050	1,800
Neurosurgery	190%	2,650	2,450
Pulmonary-Internal Medicine	195%	3,600	3,350
*Physical Medicine and Rehabilitation	75%	3,200	(800)
*Anesthesiology	95%	21,000	(1550)
*Nuclear Medicine	N/A	4,000	N/A
*Pathology	125%	13,500	3,350
*Radiology	155%	18,000	9,800
*Neurology	160%	5,500	3,150

\*The requirements in these six specialties were estimated crudely after a review of the literature. They should be considered as very rough approximations, and tentative. The full GENAC modeling methodology will be applied to them in 1980-1981.

The assumptions used to project 1980 supply numbers are stated in case 2, in Note to FIGURE 2, and in footnote d), TABLE 1.

Supply numbers for Nuclear Medicine are not available.

FIGURE 1



# Advisory Panel's Recommendations on Medical Education

from the Chronicle of Higher Education - October 6, 1980

## WASHINGTON

*Following is the text of recommendations in the summary report of the federal government's Graduate Medical Education National Advisory Committee. The committee's summary condenses 107 recommendations included in its complete six-volume report to Secretary of Health and Human Services Patricia R. Harris.*

1 Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of 10 per cent by 1984 relative to the 1978-79 enrollment or 17 per cent relative to the 1980-81 entering class.

### Supportive recommendations:

A. No new allopathic or osteopathic medical schools should be established beyond those with first-year students in place in 1980-81.

B. No increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981 should occur.

C. The current Health Professions Law, which authorizes grants to health professions schools for construction of teaching facilities, should be amended to allow the Secretary of the Department of Health and Human Services to grant waivers to allow them to ignore the law's requirement to increase enrollment. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program.

D. The current Health Professions Law should be amended to allow the Secretary of the Department of Health and Human Services to waive immediately the requirement that allopathic and osteopathic medical schools, as a condition of receiving a capitation grant, maintain the first-year enrollment at the level of the preceding school year. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program.

2 The number of graduates of foreign medical schools entering the U. S. yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished, the undesirable alternative is to decrease further the number of entrants to U. S. medical schools.

### Supportive recommendations:

A. All federal and state assistance given through loans and scholarships to U. S. medical students initiating study abroad after the 1980-81 academic year should be terminated.

B. The current efforts in the private sector to develop and implement a uniform qualifying examination for U. S. citizens and aliens graduating from medical schools other than those approved by the L.C.M.E. (Liaison Committee for Medical Education) as a condition for entry into L.C.G.M.E. (Liaison Committee for Graduate Medical Examination) approved graduate training programs should be supported. Such an examination must assure a standard of quality equivalent to the standard applied to graduates of Liaison Committee on Medical Education accredited medical schools. These U. S. citizens and aliens must be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination. The Educational Commission for Foreign Medical Graduates (E.C.F.M.G.) examination should not be used as the basis for measurement of the competence of [American graduates of foreign medical schools] or alien physicians.

C. Alien physicians, who enter the United States as spouses of U. S. citizens, should be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination prior to entry into residency training.

D. The ability to read, write, and speak English should remain a requirement for graduate medical education programs for all alien physicians.

E. The Federation of State Medical Boards should recommend and the states should require that all applicants successfully complete at least one year of a G.M.E. [graduate medical-education] program that has been approved by the L.C.G.M.E. and successfully pass an examination prior to obtaining unrestricted licensure. The examination should assure a standard of quality in the ability to take medical histories, to do physical examinations, to carry out procedures, and to develop diagnostic and treatment plans for patients. The standard of quality should be equivalent to graduates of United States medical schools.

F. The states should severely restrict the number of individuals with limited licenses engaged in the practice of medicine. This restriction applies to those practicing independently without a full license and to those practicing within an institution without adequate supervision.

G. The "fifth Pathway" for entrance to approved programs of graduate medical education should be eliminated.

H. The transfer of U. S. citizens enrolled in foreign schools into advanced standing in U. S. medical schools should be eliminated.

3 The need to train nonphysician health care providers at current levels should be studied in the perspective of the projected oversupply of physicians.

4 To correct shortages or surpluses in a manner not disruptive to the G.M.E. system, no specialty or subspecialty should be expected to increase or decrease the number of first-year trainees in residency or fellowship training programs more than 20 per cent by 1986 compared to the 1979 figure.

5 In view of the aggregate surplus of physicians projected for 1990, medical school graduates in the 1980's should be strongly encouraged to enter those specialties where a shortage of physicians is expected or to enter training and practice in general pediatrics, general internal medicine, and family practice.

6 Extensive research on the requirements for N.P.'s [nurse practitioners], P.A.'s [physician's assistants], nurse-midwives, and other nonphysician providers should be undertaken as soon as possible. Special attention must be given to the effect of a physician excess on their utilization and to the benefits these providers bring to health care delivery. These studies should consider the full range of complementary and substitute services.

**7** Until the studies in Recommendation 6 have been completed, the number of P.A.'s, N.P.'s, and N.M.W.'s [nurse-midwives] in training for child medical care, adult medical care, and obstetrical/gynecological care should remain stable at their present numbers. Delegation levels recommended by G.M.E.N.A.C. for 1990 are: in obstetrics/gynecology 197,000 of the normal uncomplicated deliveries (5 per cent of all deliveries), 7.1 million maternity-related visits (20 per cent of the obstetrical caseload), and 7.5 million gynecological visits (19 per cent of the gynecological caseload); in child care not more than 46 million ambulatory visits (16 per cent of the child ambulatory caseload); and in adult medical care not more than 128 million ambulatory visits (12 per cent of the adult medical ambulatory caseload).

**8** All incentives for increasing the class size or the number of optometric or podiatric schools should cease until the studies in Recommendation 6 have been completed and evaluated.

**9** State laws and regulations should not impose requirements for physician supervision of N.P.'s and P.A.'s, beyond those needed to assure quality of care.

Supportive recommendations:

A. State laws and regulations should be altered as necessary so that a P.A. or N.P. working under appropriate physician supervision can independently complete a patient encounter for conditions which are deemed delegable.

B. The states should provide P.A.'s, N.P.'s, and nurse-midwives with limited power of prescription, taking necessary precaution to safeguard the quality of care including explicit protocols, formularies, and mechanisms for physician monitoring and supervision.

C. At a minimum, P.A.'s, N.P.'s, and nurse-midwives should be given power to dispense drugs in those settings where not to do so would have an adverse effect on the patient's condition.

D. States, particularly those with underserved rural areas, should evaluate whether the laws and regulations pertaining to nonphysician practice discourage nonphysician location in these areas.

**10** The requirements of third party payors for physician supervision should be consistent with the laws and regulations governing nonphysician practice in the state.

**11** Medicare, Medicaid, and other insurance programs should recognize and provide reimbursement for the services by N.P.'s, P.A.'s, and nurse-midwives in those states where they are legally entitled to provide these services. Services of these providers should be identified as such to third party payors and reimbursement should be made to the employing institution or physician.

**12** N.P.'s, P.A.'s, and nurse-midwives should be eligible for all federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps Scholarship Program.

**13** Graduate medical education should be constructed to give residents experience in working with P.A.'s, N.P.'s, and nurse-midwives to insure that these physicians will be prepared to utilize nonphysician services.

**14** G.M.E.N.A.C. recommends that the basic unit for medical manpower planning should be a small geographic area within which most of the population receives a specified medical service. These functional medical service areas, service by service, are recommended as the geographic units for assessing the adequacy of manpower supply.

**15** G.M.E.N.A.C. encourages the support of efforts within the profession to assess the outcomes of common medical and surgical practices exhibiting high variation across communities. Accomplishing this step would help to establish long-range requirements for physician services in the United States.

**16** Variations between communities in the utilization of specific medical services should be continued.

**17** G.M.E.N.A.C. recommends that health manpower shortage area be defined by a minimum service specific physician to population ratio and a maximum travel time to service for child care, adult medical care, obstetrical services, general surgical services, and emergency medical services.

Supportive recommendations:

A. The minimum acceptable physician to population ratio for any area in the U. S. should be 50 per cent of the requirements estimated by G.M.E.N.A.C. for each type of health service in the nation as a whole.

B. Maximum travel times to service for 95 per cent of the population within a geographic area should be 30 minutes for child care, adult medical care, and emergency medical service; 45 minutes for obstetrical care; and 90 minutes for general surgical services.

**18** Alternative data systems for monitoring the geographic distribution of physicians should be developed and evaluated.

**19** Medical students should be encouraged to select a location for practice in underserved rural and urban areas by several approaches: (1) urban and rural preceptorships should be continued and expanded by those schools having an interest, (2) governmental loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving geographic distribution, (3) loan forgiveness programs modeled after those which have been successful should be used, and (4) the National Health Service Corps and its scholarship program should be supported.

**20** The medical profession in making decisions as to residency training programs should consider the aggregate number of programs, their size, and the geographic distribution of their graduates, in addition to the quality of the program, in light of national and regional needs.

**21** Family practice residency training programs should be supported since these programs tend to train providers who are more likely to choose to practice in underserved areas.

A similar rationale underlies support needed for resident experiences in underserved areas and for certain nonphysician provider training programs.

**22** Area-wide programs of decentralized medical education and service such as W.A.M.I. (Washington, Alaska, Montana, and Idaho), W.I.C.H.E. (Western Interstate Commission for Higher Education), and some A.H.E.C.'s (Area Health Education Centers) should be evaluated for replicability. Such programs have been effective in placement of physicians in sparsely populated areas.

**23** More research and evaluation should be conducted on factors relating to the geographic distribution of physicians.

- 24 Medical education in the medical schools and in the early phase of graduate medical education in the teaching hospitals should provide a broad-based clinical experience with emphasis on the generalist clinical fields. A portion of graduate medical training should occur in other than tertiary care medical centers.

25 A more vigorous and imaginative emphasis should be placed on ambulatory care training experiences.

Supportive recommendations:

A. The out-patient services of the academic medical centers should be upgraded through special project grants.

B. Educational innovation in out-patient settings should be fostered by providing financial support.

C. Faculty should be encouraged and supported to develop careers focused on ambulatory medicine through a career development award mechanism.

- 26 Greater diversity among the medical students should be accomplished by promoting more flexibility in the requirements for admission; by broadening the characteristics of the applicant pool with respect to socio-economic status, age, sex, and race; by providing loans and scholarships to help achieve the goals; and by emphasizing, as role models, women and under-represented minority faculty members.

27 Information about physician manpower needs in the various specialties and in different geographic settings should be disseminated broadly to medical schools; administrators; faculty; and medical students, residents, fellows, and spouses.

- 28 Capitation payments to medical schools for the sole purpose of increasing class size or for influencing specialty choice should be discontinued in view of the impending surplus of physicians.

- 29 Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued in order to continue and to increase the emphasis on primary care services and ambulatory care.

Supportive recommendations:

A. Family practice programs, at least for the near term, should be given special attention in view of the difficulty in financing training programs from ambulatory care revenues.

B. Specialties in short supply should be considered for special project grants.

30 Ambulatory care training should be promoted further by the provision of grants for renovation and construction of facilities, for the support of training programs in ambulatory sites, and for student preceptorships and residency experiences in out-of-hospital care.

31 The medical profession, having the major responsibility for correcting physician oversupply, should insure the quality of all graduate medical education programs and full funding of these programs through reimbursement should be given only to accredited programs when mechanisms are in place.

- 32 Calculations of the true costs of graduate medical education should include the compensation for residents and teaching personnel and all of the ancillary and indirect costs, should distinguish between the cost of education and the cost of patient care by a uniform recognized reporting system. Costs should be borne equitably by all payors as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided to the extent that such costs are not financed by tuition, grants, or other sources of revenue.

33 The health professions should assume a major responsibility for cost containment in new program development, in accreditation and certification, and in the provision of health services.

- 34 Public and private reimbursement policies should be adjusted to: emphasize ambulatory care services and training; encourage practice in underserved areas; explore the concept of shared risk among physicians; and pay professional fees to teaching physicians where their services have been identifiably discrete and necessary.

35 Continuous monitoring and evaluation of existing and new financial programs should be supported. Actions undertaken to alter financing and reimbursement strategies should not be advanced as permanent mechanisms for change until adequate evaluation/demonstration efforts have been performed.

36 Additional research should be accomplished on a broad array of topics related to financial considerations.

37 Special project grants for states on a cost sharing basis should be considered to influence the geographic distribution of physicians within the states. The development of incentives for practice in underserved areas is one program to be considered.

- 38 The development of future medical faculty, administrators, and researchers should be assured by provision of adequate financial support for their training.

- 39 A successor to the Graduate Medical Education National Advisory Committee should be established by statute. This successor should be an advisory body without regulatory functions.

40 In addition to the continuous monitoring, the supply projections, requirements estimates, and recommendations of G.M.E.N.A.C. in their entirety must be reevaluated and modified at least every five years to take account of changes in data, assumptions, and priorities occurring over time.

EFFECTS OF GMENAC'S RECOMMENDED REDUCTION IN FIRST YEAR ENROLLMENT

Fully-Accredited Medical Schools	1978 <sup>1</sup> 1st Year Enrollment	1982 Projection <sup>2</sup> 1st Year Enrollment	10% Reduction <sup>3</sup> 1978 1st Year Enrollment	Projected 1982 <sup>4</sup> 1st Year Enrollment Reduced by 18%
Alabama	169	170	152	139
Alabama, South	70	70	63	57
Albany	128	128	115	105
Albert Einstein	186	188	167	154
Arizona	88	89	79	73
Arkansas	138	145	124	119
Baylor	167	169	150	139
Boston University	141	139	127	114
Bowman Gray	107	113	96	93
Brown	62	60	56	49
U. California, Davis	102	100	92	82
U. California, Irvine	106	109	95	89
U. California, Los Angeles	145	146	131	119
U. California, San Diego	129	129	116	106
U. California, San Francisco	159	159	143	130

<sup>1</sup>Source: AAMC Medical School Admission Requirements, 1980-81.

<sup>2</sup>For fully-accredited medical schools 1979 first year enrollment was used as a projection for 1982 first year enrollment. For provisionally-accredited schools the 1982 first year enrollment projection was based on figures from Medical Schools of the U.S.A., Status of Accreditation, June 20-21, 1980.

<sup>3</sup>GMENAC's recommendation is for a 10% aggregate decrease in first year enrollment based on 1978 entering class size.

<sup>4</sup>An 18% reduction from 1982 first year enrollment is required to meet GMENAC's recommendation for a 10% aggregate decrease, from 1978 first year enrollment figures.

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
U. Southern California	136	144	122	118
Case Western Reserve	147	146	132	120
Chicago Medical	120	119	108	98
U. Chicago--Pritzker	104	104	94	85
Cincinnati	199	198	179	162
Colorado	128	129	115	106
Columbia	150	149	135	122
Connecticut	83	82	75	67
Cornell	96	105	86	86
Creighton	109	113	98	93
Dartmouth	67	65	60	53
Duke	120	119	108	98
Emory	115	112	103	92
Florida	116	117	104	96
Florida, South	96	99	86	81
Georgetown	205	206	185	169
George Washington	155	152	140	125
Georgia	181	185	163	152
Hahnemann	192	190	173	156
Harvard	167	166	150	136
Hawaii	68	68	61	56
Howard	139	143	125	122
Illinois	344	354	310	290
Illinois, Southern	74	73	67	60

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
Indiana	320	318	288	261
Iowa	175	177	156	145
Jefferson	235	223	212	183
Johns Hopkins	121	120	109	98
Kansas	202	202	182	166
Kentucky	110	110	99	90
Loma Linda	149	150	134	123
Louisiana, New Orleans	183	192	165	157
Louisiana, Shreveport	106	104	95	85
Loyola--Stritch	153	152	138	125
Maryland	181	181	163	148
Mayo	41	41	37	34
Meharry	149	156	134	128
Miami	144	180	130	148
Michigan State	117	110	105	90
U. Michigan	247	244	222	201
Minnesota--Duluth	48	48	43	39
Minnesota--Minneapolis	243	251	219	206
Mississippi	154	153	139	125
Missouri, Columbia	113	111	102	91
Missouri, Kansas City	83	84	75	69
Mount Sinai	102	103	92	84
Nebraska	152	154	137	126
Nevada, Reno	49	49	44	40

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
New Jersey Medical	154	179	139	147
Rutgers	114	110	103	90
New Mexico	75	73	68	60
New York Medical	180	181	162	148
New York University	171	173	154	142
SUNY--Buffalo	142	138	128	113
SUNY--Downstate	221	225	199	185
SUNY--Stony Brook	63	60	57	49
SUNY--Upstate	150	150	135	123
North Carolina	161	162	145	133
North Dakota	67	68	60	56
Northwestern	177	173	159	142
Ohio, Medical College of	133	142	120	116
Ohio State	251	258	226	212
Oklahoma	178	176	160	144
Oregon	117	116	105	95
Pennsylvania, Medical College of	102	104	92	85
Pennsylvania State	97	99	87	81
U. Pennsylvania	160	160	144	131
Pittsburgh	136	139	122	114
Rochester	101	97	91	80
Rush	122	120	110	98
St. Louis University	155	155	140	127
South Carolina, Medical Univ. of	169	167	152	137

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
South Dakota	68	66	61	54
Stanford	86	86	77	71
Temple	184	187	166	153
U. Tennessee	221	215	199	176
U. Texas, Dallas	207	207	186	170
U. Texas, Galveston	208	206	187	169
U. Texas, Houston	159	214	143	175
U. Texas, San Antonio	214	208	193	171
Texas Tech	62	84	56	69
Tufts	151	149	136	122
Tulane	150	151	135	124
Uniformed Services	108	129	97	106
Utah	102	100	92	82
Vanderbilt	104	106	94	87
Vermont	83	93	75	76
Virginia, Eastern	80	99	72	81
Virginia, Medical College of	168	168	151	138
U. Virginia	138	143	124	117
Washington U. (St. Louis)	128	124	115	102
U. Washington	175	181	158	148
Wayne State	256	257	230	211
West Virginia	88	89	79	73
Wisconsin, Medical College of	180	201	162	165
Wright State	79	106	71	87
Yale	102	102	92	84



Provisionally-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
Morehouse	27	64	22	52
East Carolina	37	64	33	52
Northeastern Ohio	49	100	44	82
Oral Roberts	25	48	23	39
Puerto Rico, Ponce	28	60	25	49
Puerto Rico, Escuela de Medicina de Cayey	80	80	72	66
U. South Carolina	37	64	33	52
East Tennessee	24	72	22	59
Texas A & M	32	96	29	79
Marshall University	26	48	23	39
TOTALS	16,501	18,151	14,851	14,883

TABLE 6  
ILLUSTRATIVE RATES OF ENTRY INTO  
FIRST-YEAR GRADUATE MEDICAL EDUCATION PGY-1 IN 1986

	PROJECTED 1990 SURPLUS (SHORTAGE)	1979 GME ENTRY RATES AT PGY-1 LEVEL	1986 ILLUSTRATIVE TREND PERCENT CHANGE	1986 GME ENTRY RATES AT PGY-1
<b>TOTAL</b>		20,474	-2	20,030
Osteopathic Interns	1,150	1,050	-2	1,030 <sup>a/</sup>
Flex Interns	N.A.	1,325	+15	1,500 <sup>b/</sup>
Family Practice General Pediatrics and Subspecialties	3,100	2,347	c/	2,347
General Internal Medicine	4,950	2,030	c/	2,030
OB/GYN	3,550	6,730	c/	6,730
*Neurology	10,450	1,100	-20	880
Dermatology	3,150 *	113	0	113
Psychiatry	400	13	0	13
General Surgery	(8,000)	714	+20	856
Neurosurgery	11,800	2,817	-20	2,254
Ophthalmology	2,450	31	-20	25
Orthopedic Surgery	4,700	65	-20	52
Otolaryngology	5,000	240	-20	192
Urology	500	40	0	40
Emergency Medicine	1,650	60	-2	48
*Anesthesiology	(4,250)	225	N.A. <sup>d/</sup>	400
*Pathology	(1,550)*	400	-10	510
*Physical Med. & Rehab.	3,350 *	559	-5	531
*Radiology	(800)*	85	+20	102
	9,800 *	470	-20	376

a/ Derived using the same proportional decrease (minus 2 percent) in the total number of positions for allopathic medicine between 1979-80 and 1986-87.

b/ These positions provide the first year clinical training for several specialties and are likely to be called the transitional year in the future. Therefore, GMENAC suggests a 15 percent increase in the number of these positions.

c/ While the 1990 projected supply is slightly greater than requirements for all three of these specialties, GMENAC suggests that the current number of available positions be retained in order to accommodate as many residents as possible in these three, as opposed to other, specialties.

d/ See Note 7 in NOTES to TABLES 1-7 on page 14.

\* The requirements in these five specialties were estimated crudely after a brief review of the literature. They should be considered approximations, and tentative. The full GMENAC modeling methodology will be applied to them in 1980-81.

MEDICARE'S ALTERED POLICY ON REIMBURSEMENT OF  
"MOONLIGHTING" RESIDENTS

Two years ago, Medicare officials found that residents in the Welsey Medical Center in Wichita, Kansas, were being compensated by a physician group operating the Center's emergency room. Services provided by residents working in a "moonlighting" status were billed on a fee for service basis in the name of the group. This payment to residents for services in a "moonlighting" status in the same institution providing their graduate education was counter to Medicare policy and reimbursement under Part B was disallowed. The hospital sued the Secretary of HEW alleging that because "moonlighting" residents could be paid on a fee for service basis in settings other than in the hospital responsible for their graduate medical education, the policy disallowing reimbursement for services in their emergency room was arbitrary, capricious and discriminating. The Federal District Court in Kansas agreed and ordered Medicare to change the policy.

Medicare's proposed policy change will permit "moonlighting" residents to be paid on a fee for service basis regardless of the hospital in which the service is provided. The proposed policy requires that, "the 'moonlighting' services are performed under the terms of a written contract or agreement and can be separately identified from those services that are required as part of the training program" (see page 68). This change in Medicare policy, which resulted from a court order, is not likely to be reversible. It may result in significant problems for the following reasons:

1. Separating patient care responsibilities which are necessary for education from patient care responsibilities which are not necessary for education and setting these down in a written agreement will be difficult, given the non-specific nature of the special requirements of most residency review committees;
2. Some hospitals in order to attract residents or to reduce their obligation to pay increased stipends from hospital reimbursements may provide "in-house moonlighting" opportunities by arbitrarily limiting the service responsibilities for their educational programs, thus freeing time for residents to work as physicians in their facilities rather than being in an educational status.

In 1974, the Association adopted the following policy on "moonlighting":

Graduate medical education should be a full time educational experience. House officers should not be diverted from their primary responsibilities to their own education and to the patients charged to their care by the training institution by engaging in extramural professional activities. Therefore, as a matter of general principle, the Association of American Medical Colleges believes that "moonlighting" by house officers is inconsistent with the education objectives of house officer training and is therefore a practice to be discouraged.

For those institutions which permit "moonlighting," great care should be taken to preserve the educational character of their graduate medical education programs. The following general guidelines are recommended

as the means by which the primary training institutions should monitor and control this practice:

1. The hospital governing board or executive committee of the faculty having responsibility for medical standards in the educational setting, should administer the authority to approve or disapprove "moonlighting" in the individual case. This authority may be delegated to the service chief or other individual who controls the content and quality of each training program.
2. In evaluating the content and quality of the training program for each house officer, consideration should be given to the following:
  - a. The capacity of the house officer to fulfill his educational objectives while, at the same time, pursuing additional work opportunities for income;
  - b. The nature of the work opportunity, including its educational value;
  - c. The needs of the community; and
  - d. The financial need of the individual.
3. "Moonlighting" by incumbents of internships and residencies approved by the Liaison Committee on Graduate Medical Education, may be permitted only if those activities are reviewed and approved by the person(s) responsible for the individual's graduate training program. House officers should be informed of the substance of this provision prior to appointment.
4. The LCGME should take the necessary steps in its process of approval of graduate medical education programs to assure compliance with the above guidelines.

The new general requirements of the essentials of accredited residencies will require that hospitals and/or programs provide residents with a written statement on practice privileges and other activities permitted outside the educational program. Teaching hospital administrators, program directors and faculty will have to review their policies on these matters and come to positions consistent with maintaining the educational quality of their programs. The fact that Medicare permits residents to be reimbursed on a fee for service basis if they provide physicians' services to beneficiaries outside of their educational activities need not compel institutions to permit "moonlighting" either within their facilities or elsewhere. Although these changes in reimbursement policy may increase the pressures from residents to augment their stipends by after-hours work, policies of teaching hospitals must be based on preserving the quality of their educational program and the residents' educational developments.

B. Services Furnished by Interns and Residents Outside the Scope of their Training Program. The Medicare program reimburses for medical and surgical services furnished by residents and interns that are not related to the intern's or resident's training program and that are performed in an outpatient department or emergency room of a hospital. Such services may be covered as "physicians" services, reimbursable on a reasonable charge basis, but only where all of the following criteria are met:

1. the services are identifiable physicians' services, the nature of which requires performance by a physician in person and which contributes to the diagnosis or treatment of the patient's condition; and

2. the intern or resident is fully licensed as a physician for purposes of performing the services; and

3. the services are performed under the terms of a written contract or agreement and can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns or residents.

The Medicare carrier is expected to review the contracts/agreements for such services to assure compliance with the above criteria.

## ACCREDITATION COMMITTEES REORGANIZED

From their inception in 1972, the Coordinating Council on Medical Education, the Liaison Committee on Graduate Medical Education and the Liaison Committee on Continuing Medical Education have been plagued by conflict and controversy. In 1979, the AMA withdrew from the LCGME and established a separate accrediting committee for continuing medical education. In 1980, the American College of Surgeons threatened to establish a separate system for the accreditation of programs in surgical specialties unless changes were made in the LCGME and its functions. These events were merely reflective of the long-standing difficulties the sponsoring organizations of the two liaison committees have had in reaching agreements on policies and operating principles.

In September, after a series of conferences among the senior elected officers and chief executive officers of the ABMS, AMA, AHA, AAMC and CMSS, the five organizations announced plans to reorganize the accreditation system. The old organization and relationships are shown in Figure 1; the new organization relationships are shown in Figure 2.

The Coordinating Council on Medical Education has been abolished. In its place the Council for Medical Affairs has been established with representation by the two top elected officers and the chief executive officers of each organization. The CFMA will provide a forum for discussion of medical education issues and other matters of mutual concern to the organizations. The CFMA will not have a direct role in accreditation.

The Liaison Committee on Medical Education will continue unchanged in sponsorship, representation and function.

The LCGME will be replaced by an Accrediting Council on Graduate Medical Education (ACGME). The ACGME will have the representation shown in Figure 2. Staff services will be provided by the American Medical Association under the conditions of a letter of agreement. Revenues to pay for the cost of accreditation will be generated by charges to programs. This will probably be a combination of an annual charge based on the number of positions in a program and an additional charge for periodic review and accreditation. The ACGME sponsors will pay for the cost of ACGME meetings and policy development activities.

The ACGME will have the authority to accredit graduate medical education programs which have been recommended for accreditation by residency review committees. It will establish policies and procedures for residency program accreditation. Residency review committees may continue to forward their accreditation recommendations to the ACGME or a RRC may request that the authority to accredit be delegated to it. The ACGME may grant such authority on a time limited basis, subject to monitoring and periodic review. Program directors will be informed of residency review committee recommendations or accreditation decisions after each residency review committee meeting. This will eliminate the delays caused by waiting until the LCGME takes action. Such delays have been a constant source of irritation and frustration.

The ACGME will be responsible for the General Requirements section of the Essentials of Accredited Residencies. Changes in the general requirements must be unanimously approved by the five sponsors. Residency review committees will be responsible for the special requirements subject to review of their sponsoring organizations. The ACGME will approve all special requirements.

The structure and functions documents establishing the operations of residency review committees will be developed by the residency review committees within guidelines established by the ACGME and will be subject to approval by the ACGME. The ACGME will be responsible for the procedures for appealing adverse accreditation decisions.

Only specified items will require unanimous approval by the sponsoring organizations. The General Requirements of Accredited Residencies and the bylaws must be ratified by all sponsors. Action within 180 days of receipt is required. A sponsor failing to act within that time will be considered to have given approval. Fiscal policies (including fees, service charges, member assessments, grant applications and the annual budget) and authorizations of new programs and activities must be approved by two-thirds of the members of the ACGME present and voting. Any sponsoring organization may request within 45 days of the vote the submission of any item so approved to all sponsoring organizations. Each sponsoring organization then must approve before the item becomes effective. A sponsoring organization must act within 90 days of receipt of such an item or it shall be deemed to have approved it.

The Liaison Committee on Continuing Medical Education will be replaced by an Accrediting Council on Continuing Medical Education. Representation on the Council will be as shown in Figure 2. Staff services for the ACCME will be provided by the Council of Medical Speciality Societies under the conditions of a letter of agreement. Revenue to pay for the cost of accreditation will be generated by charges to organizations sponsoring CME programs. The ACCME sponsors will pay for the expenses of meetings and policy development activities.

Intrastate continuing medical education programs will be accredited by state associations or consortia under standards developed by the ACCME. The ACCME will be the accrediting authority for interstate and medical school sponsored programs. The items subject to unanimous approval by the sponsors will be the same as for the ACGME.

This reorganization and agreement on policies and procedural matters was achieved in an atmosphere of cooperation and mutual concern for improving the accreditation of medical education.

Figure 1

RELATIONSHIPS AMONG PARENT ORGANIZATIONS, COORDINATING COUNCIL ON MEDICAL EDUCATION, AND LIAISON COMMITTEES 1980

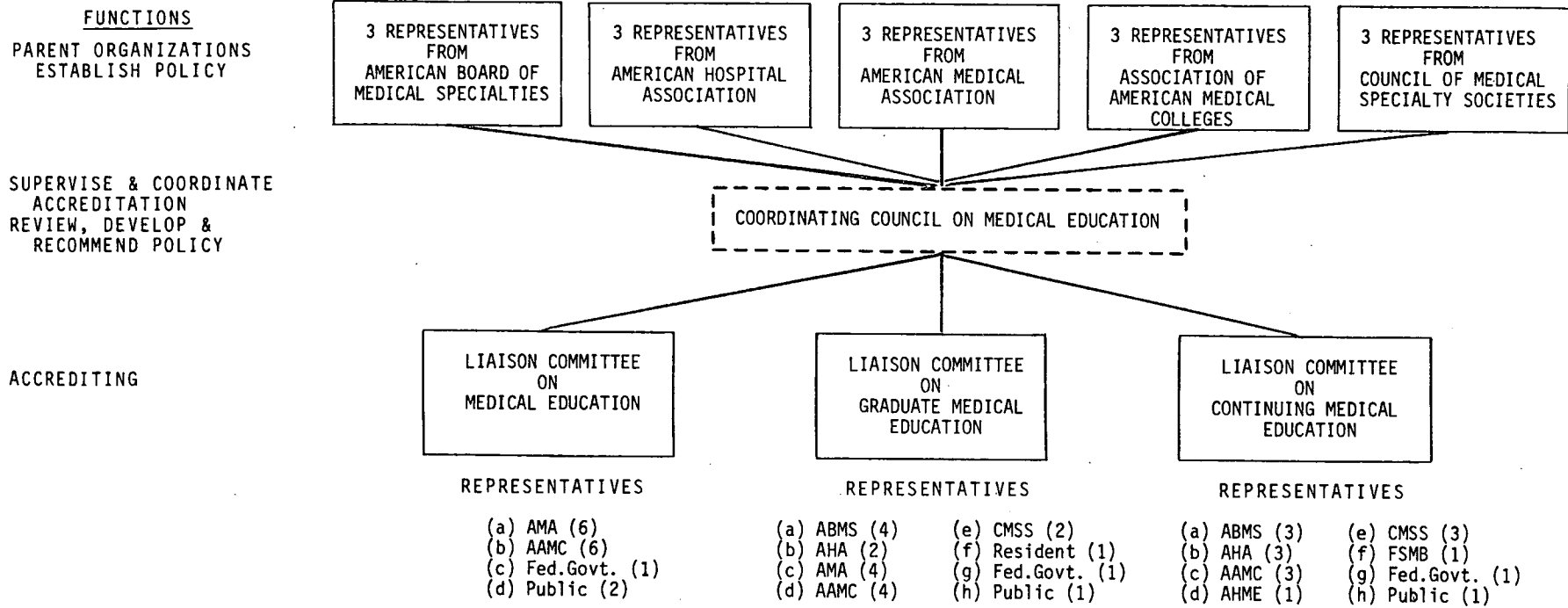


Figure 1

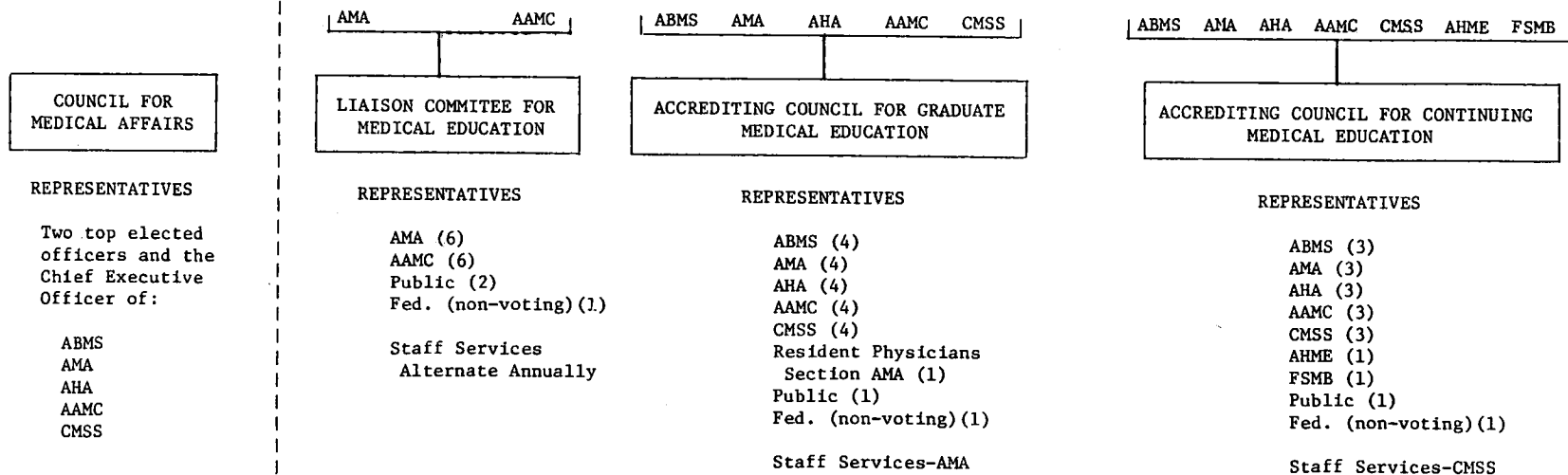
AMA	American Medical Association	AHA	American Hospital Association	AHME	Association of Hospital Medical Education
AAMC	Association of American Medical Colleges	CMSS	Council of Medical Specialty Societies	FSMB	Federation of State Medical Boards
ABMS	American Board of Medical Specialties				

SOURCE: American Board of Medical Specialties. Annual Report, 1978-1979. Evanston, Illinois: American Board of Medical Specialties, 1979. (Revised 1/1980, Association of American Medical Colleges).



Figure 2

ACCREDITATION BODIES FOR MEDICAL EDUCATION



ABMS - American Board of Medical Specialities  
 AMA - American Medical Association  
 AHA - American Hospital Association  
 AAMC - Association of American Medical Colleges

CMSS - Council of Medical Speciality Societies  
 AHME - Association of Hospital Medical Educators  
 FSMB - Federation of State Medical Boards

Figure 2

## UNIVERSAL APPLICATION FORM FOR GRADUATE MEDICAL EDUCATION

The Association's Task Force on Graduate Medical Education recommended that to assist students during their transition from undergraduate to graduate medical education a universal application form should be developed. The purpose would be to reduce the need for students to write for multiple applications and provide diverse information in varying formats.

Based upon an analysis of over 100 forms, the staff of the Division of Student Programs developed a draft form in 1979. This was distributed to program directors through hospital NRMP coordinators, to student affairs deans in the medical schools and to selected students. Critical comments and suggestions were requested. Based on the returns from that distribution, the draft form was revised and in July 1980 the revision was sent to program directors through hospital NRMP coordinators with the request that a response be returned indicating whether the form would be acceptable. The results of this survey are shown below.

Total hospitals mailed to:	671
Total programs represented:	2996*
Number of responses received:	358 (53% of total mailed to)
No. of programs represented:	1516 (50% of total represented)
Hospitals accepting form:	299 (84% of response)
No. of programs represented:	1067 (70% of response)
Hospitals not accepting form:	19 (5% of response)
No. of programs represented:	92 (6% of response)
Hospitals reporting split reaction:	40 (11% of response)
	262/357 programs accept form (18% of response)
	95/357 programs do not accept form (6% of response)
Total no. of programs accepting form:	1329 (88% of response)

\*This number is based upon entries in the NRMP Directory for 1980 Appointments. It includes programs starting at other than the first year of graduate medical education. Also, in many cases, the number of programs reported by the hospitals differs from the number shown in the Directory.

The Executive Council has authorized the implementation of the Universal Application Form in the spring of 1981 for students applying to programs for their first graduate year starting in 1982.

The form will be provided to medical schools in sufficient numbers so that students may send an original copy to each program to which they apply. However, the form is designed so that biographic information commonly required by all hospitals and programs is on pages three and four. These pages could be prepared once and duplicated.

Programs requiring additional information will be free to request that applicants submit a supplementary form.

An acknowledgement card to inform applicants of the receipt of the application and a program designation card for the use of the program or hospital is included with each form.

With over 95 percent of a larger and larger graduating class applying for graduate medical education, the introduction of a universal application form is one step toward reducing the strain of the transition between undergraduate and graduate medical education for students and for programs.

GENERAL ACCOUNTING OFFICE STUDY OF U.S. CITIZENS IN  
FOREIGN MEDICAL SCHOOLS

During 1979-80, the General Accounting Office undertook a study of U.S. citizens studying medicine abroad at the request of the House Subcommittee on Health and Environment. The Congress was concerned about the adequacy of medical education provided to U.S. citizens studying abroad and the impact of their returning to the United States with the expectation of developing careers as practicing physicians in this country at a time when our own domestic schools are facing resource curtailments. The growing perception of a possible physician surplus was also a concern. Additionally, through authorities established in the Higher Education Act of 1966, the Department of Education has provided guaranteed student loans to U.S. citizens studying abroad if such education is comparable to the education they might receive in this country. The Department of Education has never established standards of comparability for medical education in foreign institutions.

The study focused on six schools which the GAO estimated enrolled one-half of the U.S. citizens studying abroad. They were: University Central del Este, Dominican Republic; University of Nordestana, Dominican Republic; St. George's University, Grenada; Autonoma University of Guadalajara, Mexico; University of Bologna, Italy and the University of Bordeaux, France.

The study found major differences between these six institutions and U.S. medical schools in their admission requirements, facilities, equipment, faculty, curricula and clinical training resources. The GAO has not made a formal presentation of its findings or recommendations to the Congress. Dr. Murray Grant, Medical Consultant to the General Accounting Office, will present a summary of the report at the Assembly Meeting on Tuesday morning, October 28th. The timing of the release of the official report and a response by the Association to the draft report which staff has reviewed will depend upon the Congressional schedule during the post-election period.

## MEDICAL SCIENCES KNOWLEDGE PROFILE PROGRAM

The AAMC in cooperation with the National Board of Medical Examiners administered the first Medical Sciences Knowledge Profile Examination (MSKP) June 10-11, 1980. This examination was developed to assist AAMC member schools in determining levels of attainment in the sciences basic to medicine for individuals being considered for placement with advanced standing.

Two-thousand one hundred and forty-four (2,144) registrations were processed for the 1980 MSKP examination. This compares with 2,425 who were sponsored under the COTRANS program of the previous year. Of the 2,144 registrants, 1,794 actually sat for the MSKP examination; the previous year, a total of 1,985 candidates were administered Part I of the Boards on the June and September dates. Scores were reported on a scale of 1 (lowest) to 9 (highest) for each of the following areas: Anatomy, Behavioral Sciences, Biochemistry, Introductory Clinical Diagnosis, Microbiology, Pathology, Pharmacology and Physiology. Examinees and medical school admissions officers were provided with information to assist in the interpretation of MSKP score results. This information provided the opportunity to compare an individual's performance with all other MSKP examinees and also with the predicted performance of a sample of students from U.S. medical schools. The U.S. student group was comprised of approximately 1,000 second year students from six U.S. medical schools.

The development of these norms also made it possible to compare the performance of that group of MSKP examinees most similar in stage of education to U.S. students. The performance of this subset of MSKP examinees (N=1,300) generally fell at the seventeenth percentile of the U.S. student population on most of the eight scales of the exam. Three notable exceptions were the Introduction to Clinical Diagnosis, Behavioral Sciences, and Physiology measures. These fell in the eight to tenth percentile range.

A separate analysis was made of that group of examinees who were enrolled at the ten foreign schools supplying the largest number of examinees. This group accounted for 961 or about 74% of the subset of 1,300. It is noteworthy that the schools comprising this subset were mainly those established for the express purpose of attracting U.S. citizens unable to gain acceptance in an LCME accredited school. The general pattern of performance of the students from this group of schools was almost indistinguishable from the 1,300 in terms of their relationship to the performance of U.S. students.

The MSKP program will be continued during 1981 with very little apparent need for change in policies or procedures.

## EXTERNAL EXAMINATION REVIEW COMMITTEE

In June 1980, the Executive Council appointed a committee to review the status of external examinations in medical education. The committee is chaired by Carmine Clemente and is charged to consider the development of the Comprehensive Qualifying proposal by the National Board of Medical Examiners as an examination which students would have to pass to enter the graduate phase of their education. The parallel development of a proposal by the Federation of State Medical Boards to develop a two phased licensing examination system in the states will also be scrutinized. The Federation has proposed that the state licensing boards should require passage of an examination for a preliminary license for residents to participate in patient care under supervision in educational settings. This examination has been termed the Federation Licensing Exam I (FLEX I). There is an assumption that the National Board of Medical Examiners' Comprehensive Qualifying Exam would be FLEX I. Passage of a second exam would be required for licensure for independent practice. Eligibility to sit for this exam (FLEX II) would require completing a period of graduate medical education.

The committee will review the potential impact of these developments on medical education and on the relationship between the National Board of Medical Examiners, medical school faculties and the Federation of State Medical Boards.

A major discussion of the status of development of the Comprehensive Qualifying Exam and policies relating to it is planned for the Council of Academic Societies Interim Meeting in February.

### COMMITTEE MEMBERSHIP

Carmine D. Clemente, Ph.D., Chairman  
Director, Brain Research Institute  
UCLA School of Medicine

D. Kay Clawson, M.D.  
Dean  
University of Kentucky

Henry G. Cramblett, M.D.  
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The Ohio State University

Daniel D. Federman, M.D.  
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Dean  
The University of Pennsylvania

Louis van de Beek  
OSR Representative  
Hahnemann Medical College

## DISPOSAL OF HAZARDOUS WASTES

In 1979 the three national sites for disposal of radioactive waste (in South Carolina, Washington and Nevada) were closed for a short period of time due to irregularities in the packaging and transportation of wastes from nuclear power plants. Biomedical research institutions, hospitals and radiopharmaceutical manufacturers also generate radioactive wastes which amount to between 10 and 15 percent of the total annual volume shipped to the national sites. This volume consists mostly of scintillation vials, carcasses and biological wastes. It is growing each year but is dwarfed by the wastes from a single nuclear power plant "clean-up" such as Three Mile Island. Biomedical wastes of low volume and very low specific activity must continue to flow steadily to the national sites because the storage capacity of bio-research institutions and hospitals is very limited.

It was largely the threat to the bio-research/hospital endeavor which prompted the sympathetic Washington State Governor, Dixy Lee Ray, to reopen the Hanford, Washington site in late 1979. Most observers felt this re-opening would be very temporary; therefore, the AAMC took steps to find ways to alleviate the problem during the respite provided by Governor Ray's action. Despite our best efforts, however, problems related to the disposal of hazardous wastes continue to evolve in a complex and uncertain way. With respect to radioactive wastes, AAMC has sought to gain acceptance for the concept of de minimus levels which would be those below which substances would not be regarded as radioactive. Efforts to set a de minimus level have not been entirely successful. The Presidential Radiation Policy Council and the Nuclear Regulatory Commission are expected to propose soon that scintillation vials and animal carcasses containing tritium or carbon-14 of low specific radioactivity can be treated as ordinary trash and disposed of by local burial or incineration. The Association's advisors feel that such a proposal would not completely solve the problem of medical schools and hospitals but that the change would help considerably. The disposal issue is further complicated by the combination of the primary election loss of Governor Ray to an opponent with strong environmentalist backing and an environmentalist-sponsored referendum on the November 4 ballot which is expected to force the closure of the Hanford site to nuclear power wastes. Although biomedical wastes could still be accepted the site operator has stated publicly that such a low-volume operation would not be feasible and that he would cease operation anyway.

The Federal initiatives may help institutions to dispose locally of some low-level wastes now regarded as radioactive. However, this advantage is likely to be short-lived as the Environmental Protection Agency (EPA) proposes new and more stringent regulations for the disposal of animal and toxic chemical wastes. Although Association staff have been unable to penetrate EPA for a preview of the animal/microbiological regulations we are not encouraged by the adjectives ("draconian," "stringent" and "foolish") used by knowledgeable consultants to describe these rules. Regulations promulgated by EPA on August 18 require the collection, labelling and control of toluene (the principal component of scintillation fluid) and dozens of other common laboratory chemicals. At this time, however, it is not clear whether or by what means local disposal of such toxic chemicals will be allowed. It is safe to predict that whatever will be permitted by EPA will be even more expensive than the present arrangements.

## CLINICAL LABORATORY REGULATION

The regulation of clinical laboratories is of interest to AAMC organizations for several reasons: Proposals for change would extend regulatory coverage to clinical research laboratories. Also regulated would be specialized clinical laboratories operated by such specialists as anesthesiologists, cardiologists, endocrinologists and emergency physicians. In addition, existing hospital clinical laboratories would be saddled with new reporting and staffing requirements which would escalate costs without improving the quality of these laboratories to any significant extent.

During the past year there have been both legislative and executive branch actions to extend regulation of clinical laboratories. The Congress quietly attempted to extend the 1967 law (which covers only interstate laboratories) to those laboratories which receive Medicare or Medicaid payments, that is to all laboratories. This effort was embodied in the 1980 Medicare Amendments, H.R. 4000. The attempt was discovered at the eleventh hour and appears to have been defeated largely due to the efforts of Congressman Satterfield (D-Va.) who introduced substitute language restraining the proposed Medicare extension and actually restricting efforts (see below) of the Department of Health and Human Services (DHHS) to impose further laboratory regulations. Neither provision passed in the regular session and the off-setting provisions and controversy engendered make it likely that neither will succeed in the lame duck session. Congressman Satterfield will not return to Congress next year. If Senator Javits (the main proponent of CLIA) is re-elected, another attempt is likely to be made in 1981.

In parallel but not directly related activities, DHHS proposed new regulations in October 1979 to prescribe credentials for all personnel who direct and work in clinical laboratories. Although these regulations were four years in the making, they pleased no one and generated more than 7000 written objections. Secretary Harris ordered the Center for Disease Control and Health Care Financing Administration to hold a joint conference to work out the problems and find solutions. Most observers at the August conference agreed that there was much heat, little light, and even less agreement. Thus, it surprises no one that rumors are now prevalent that Secretary Harris will withdraw the proposed regulations requiring credentialing of laboratory personnel. Meanwhile, just in case either Congress or the DHHS begin to move again, several CAS societies have been quietly working to draft more reasonable proposals by which those laboratories which need assistance could really be upgraded.



## SECTION 227

Paying for Physician services in teaching hospitals has been a recurring issue of the Medicare program since Congress adopted Section 227 of Public Law 92-603 in 1972. Attempts to publish implementing regulations for this legislation failed in 1973 and 1978. With several Congressmen interested in repealing the legislation, the Department of Health and Human Services appears to be waiting out any legislative changes before making another attempt at promulgating implementing regulations. In the interim, however, the DHHS Office of Planning and Evaluation has awarded a \$4.5 million, four year contract to Arthur Young and Company and several subcontractors to once again study and prepare recommendations for implementing Section 227.

On the legislative front, just prior to last year's AAMC Annual Meeting, Representative Waxman's House Subcommittee on Health and the Environment held hearings which examined, among other issues, the status of Section 227. Following those hearings, at a Subcommittee meeting in January, Representative David Satterfield of Virginia introduced legislation to repeal, in effect, Section 227. The repeal provision was adopted by the Subcommittee as an amendment to H.R. 4000. Subsequently, it was approved by the full House Interstate and Foreign Commerce Committee. The AAMC notified constituents prior to both Subcommittee and full Committee action and urged the membership to support the repeal of Section 227.

During the summer, H.R. 4000, including the provision repealing Section 227, was included in the House Budget Reconciliation Act and endorsed by the House of Representatives. That House action, H.R. 7765, is now in conference with a Senate version of the budget reconciliation act. AAMC President John Cooper wrote each House and Senate conferee in September urging them to include the repeal of Section 227 in any final budget Reconciliation bill. In addition, the Association urged its membership to contact conferees and members of Congress to support repeal of Section 227.

On September 30, Senate and House Conferees endorsed the repeal of Section 227; however, they added statutory authority to the repeal that, in effect, reimposed the onerous conditions of Section 227. Thus, the Association and its constituents are presently working with Conferees and their staffs in an effort to have the repeal of Section 227 reconsidered and modified.

## ANNOUNCEMENT OF NEW SERVICE AVAILABLE TO CAS MEMBER SOCIETIES

At its June meeting, the CAS Administrative Board approved the implementation of a new service to CAS societies--the CAS Inter-Society Communication. Stationery has been designed (which will be available at the October 27 Business Meeting for your inspection) for the purpose of communication between CAS societies. The stationery may be used to circulate *formally approved position statements* of CAS societies only. (The Administrative Board decided that positions of individuals should not be circulated in this way.) This mechanism for communication to other CAS societies will be provided at a cost of approximately \$120-\$140 which will include the cost of reprinting the statement and mailing it to the officers and representatives of all CAS societies (approximately 380 individuals). The papers, which may be a maximum of four pages in length, are to be submitted to the CAS staff in final, printable form and will not be retyped or edited in any way. Societies which are interested in disseminating a position paper via the CAS Inter-Society Communication should contact Diane Plumb for further information.

FUTURE MEETING DATES

1980 CAS Fall Meeting

October 26, 1980	Plenary Session and Discussion Groups
October 27, 1980	Business Meeting

1981 CAS Interim Meeting

February 26, 1981	Plenary Session and Discussion Groups
February 27, 1981	Business Meeting

1981 CAS Administrative Board Meetings

January 28-29, 1981  
March 25-26, 1981  
June 24-25, 1981  
September 9-10, 1981

Future AAMC Annual Meetings

October 31 - November 5, 1981  
(Tentative CAS Meetings, November 1-2)  
November 6-11, 1982  
(Tentative CAS Meetings, November 7-8)