

ADMINISTRATIVE BOARD

of the

COUNCIL OF DEANS

* * *

September 16, 1970
Dupont Plaza Hotel
Executive Room

7:30 - 9:00 a.m.
BREAKFAST

* * * * *

AGENDA

- I. Consideration of Minutes of May 7, 1970 Meeting..... 1
- II. Legislative Activities
- III. COD Fall Program
- IV. Medicare..... 4
- V. NIRMP..... 10
- VI. Material from Deans of New & Developing Schools..... 17
- VII. New Business
- VIII. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES

ADMINISTRATIVE BOARD OF COUNCIL OF DEANS

Present: Board Members

Dr. Charles C. Sprague, Presiding

Dr. William G. Anlyan

Dr. Ralph J. Cazort

Dr. Carleton B. Chapman

Dr. Kenneth R. Crispell

Dr. Merlin K. DuVal

Dr. Robert H. Felix

Dr. Robert B. Howard

Dr. Sherman M. Mellinkoff

Dr. Robert S. Stone

Staff

Mr. Michael Amrine

Mrs. Barbara E. Bucci

Dr. John A. D. Cooper

Mr. John M. Danielson

Mr. Joseph S. Murtaugh

Mr. J. Trevor Thomas

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
MINUTES
ADMINISTRATIVE BOARD OF COUNCIL OF DEANS

May 7, 1970

Dupont Plaza Hotel
Washington, D. C.

I. Call to Order

The meeting was called to order by Dr. Sprague at 7:20 a.m.

II. Minutes of February 6, 1970 Meeting

The Minutes of the meeting of February 6, 1970 were accepted without change.

III. Appointment of Nominating Committee

In keeping with the Bylaws of the Council of Deans, 5 members were chosen to form a Nominating Committee. Each of the regions of the Association is represented. The members who will be asked to serve are: Clifford Grobstein, Alfred Gellhorn, Robert Kugel, Emanuel Papper, and William Maloney as Chairman.

IV. COD Fall Program

Two issues seem to be most prominent: 1) how to effectively deal with the manpower question, and 2) the financing of medical education. Both of these will be discussed at the May 21st COD meeting, but no doubt will continue in the foreground.

Dr. Franz Bauer has raised the issue of tenure policy. After discussion, it was decided that the Association should poll the schools to determine the tenure policy of the individual schools plus any specific problems they have encountered in this regard. This information would then be available in the Association's offices as resource material.

With regard to agenda items suggested by the members, it was felt that rather than bring the items to the membership without adequate documentation, that the appointment of a task force might be considered; a more thorough and thoughtful presentation would probably ensue.

V. Faculty Salaries

The Southern Deans continue to express their concern about academic salary inflation and the contribution of federal funds. They are requesting that this problem be separated out of the overall issue of financing medical education being studied by a task force chaired by Dr. Russell Nelson, and be handled independently.

Dr. Cooper pointed out that the fastest growing component of faculty salaries at present is medical service plans, and that federal contributions are actually going down. The Administrative Board agreed that this was indeed the case, and that in view of this changing situation they did not favor a separate study.

VI. COD May 21, 1970 Agenda

Dr. Roger O. Egeberg will not be able to speak at the May 21st meeting; he, along with other HEW officials and Dr. Cooper, is going to Russia to study their health care system. Attempts are being made to have Lewis H. Butler, Assistant Secretary for Planning and Evaluation, DHEW, speak in Dr. Egeberg's place.

VII. Congressional Contacts

Dr. Sherman Mellinkoff, at the request of his faculty council, suggested that a national roster be developed of faculty members who personally know members of the Congress. This list could be obtained by canvassing the membership, and would be kept in Dr. Cooper's office.

There was discussion about the most effective means of having input into the decisions made by the Administration.

VIII. Specialty Boards

Dr. Kinloch Nelson has requested that the group look into the impact the specialty boards are having on the structuring of medical school organization. Dr. Cooper stated that one of the goals the AAMC is seeking is institutional accreditation for graduate education versus the present system involving the specialty boards. The matter will be brought to the attention of the LCME.

IX. Adjournment

The meeting was adjourned at 8:30 a.m.

August 21, 1970

TO: Members, Executive Council

FROM: John M. Danielson, Director, Department of Health Services
and Teaching Hospitals

SUBJECT: Attached Specifications for Testimony on Medicare and Medicaid

The attached statement was developed by the Ad Hoc Committee on Medicare at their August 17th meeting and has been circulated to them for review. Additionally it has been sent to members of the Assembly for comment and these will be available at the meeting.

We anticipate that AAMC testimony will be presented before the Senate Finance Committee about the third week in September.

8/19/70

FOR INTERNAL ASSOCIATION USE ONLY -

Tentative Specifications for Association Testimony Before Senate
Finance Committee on H.R. 17550

Outline for Preamble:

- (1) In reimbursing the physicians' services in the teaching setting, the basic problem has been to develop appropriate criteria to distinguish between a physicians' teaching services which can be covered only under the hospital insurance program on a cost basis and a physicians' personal services to patients which can be reimbursed under the medical insurance program on a fee-for-service basis. We believe the criteria for distinguishing between teaching and patient care need to be responsive to the wide variety of teaching settings in which physicians practice. At the same time it might be noted that the best of criteria will not meet the need unless they can be and are properly applied by carriers given the administrative difficulties which arise from the large number of differing fact situations.

- (2) The nature of Medicare reimbursement to supervisory physicians in teaching hospitals is related to the circumstances of the case. There is, of course, a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of Medicare beneficiaries may, substantially be the responsibility of the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisory and have not acted as any one patient's physician.

- (3) At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major portion of the care and directs in details the totality of the care.
- (4) Additionally, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment and who have been assigned by the hospital to his care.
- (5) With the change in the tax status, the pressure of private patient demand both in number and time and increased specialization which requires more time spent with each private patient, the voluntary physician has found it increasingly difficult to provide service to indigent patients without some compensation. The physician's time has become such an important part of his financial solvency he could no longer give it away and the institution's can not buy it and give it away, but they can buy it and sell it.
- (6) The salaried physician has similarly found that; because of increasing demands made by their responsibilities for administration or professional management, the demands for their time by the house staff and students, the complications of specialization, pressure to engage in productive research as a requirement of faculty advancement; coupled with a serious lack of funds on the part of the institution to meet the necessary level of salary which they require for an appropriate standard of living, it is necessary for them to be compensated similarly for the care of the indigent patient.

- (7) When Medicare and Medicaid offered a solution to some of the above problems by offering to pay professional services rendered to their beneficiaries, it was considered almost fortuitous that a method of reimbursement had been authorized by the law that could and did in fact resolve the problems stated above and guaranteed the poor of this nation continued and improved accessibility to care and quality of professional care that, if not provided, may have caused a major breakdown.
- (8) It is necessary therefore that legally acceptable methods of financial reimbursement be developed that will provide for a resolution of the existing problems in the reimbursement of attending physicians (voluntary, full-time and geographic full-time) in a teaching setting.

Outline of Specifications of Suggested Alternative Methods of Payment
for Services of Attending Physicians in a Teaching Setting

1. It is necessary to emphasize that the Association believes that, because of the variability of circumstances and situations in differing teaching settings each of these alternatives must be legislatively permitted. No one of the following alternatives must be considered to have preferential endorsement by the Association.

It must also be emphasized that all of the following legislative recommendations would, we believe, fulfill the intent of the law, and would insure a high quality of care for each Medicare beneficiary admitted to a hospital.

a. All Part A

All reimbursement of attending physicians, including the imputed cost of voluntary faculty as well as House Staff would be based on a cost related formula as a part of hospital costs.

b. All Part B

The services of all licensed physicians in a teaching setting including both attending physicians and residents, would be paid under the Part B. The costs of interns would be included under Part A.

c. Interns and Residents would continue Part A and attending physicians would charge the established professional fee less some predetermined amount which recognizes that care in a teaching setting is rendered by a team and not an individual physician.

A recommended variant of this approach is as follows:

$$\frac{\text{Accumulated Professional Fee By Service}}{\text{Patient Days}} = \frac{\text{Average Per Diem Professional Fee}}{\text{Professional Fee}}$$

This amount would be considered the professional fee charged for a visit of service rendered by the team. This unit charge would be billed at 15 percent less when evidence is provided by the institution that the care rendered is the same throughout the institution and that there is no dual standard of care provided. Additionally, documentation must be presented relating to the quality of care the the existence of a team. Satisfactory institutional evidence of this would eliminate the necessity for the documentation now requested by IL 372 and the 15 percent reduction in the established professional fee would be an indication of this.

We also recommend that this formula relate to a maximum of 30 patients assigned to any one attending and that in those instances in which attendings are assigned up to 60 patients that an additional 15 percent

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be reduced from the coverage per diem professional fee. In those cases, where an attending is assigned more than 60 patients, we recommend that the formula be: the average per diem professional fee less 80 percent.

The virtue of a proposal such as this is that it provides financial incentives for the institution to increase the size of their attending staff.

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

State National Bank Building - Suite 1150

EVANSTON ILLINOIS 60201

EVANSTON 312-328-9505
312-328-9506

MEMBER ORGANIZATIONS

American Hospital Association
American Medical Association
Council on Medical Education
American Protestant Hospital Association
Association of American Medical Colleges
Catholic Hospital Association
Student American Medical Association
Advisory Board for Medical
Specialties, Inc.

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Public Health Service
United States Air Force
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Executive Secretary

TO: Deans of All Medical Schools
Hospital Administrators and Directors of Medical Education
Secretaries of State Boards of Medical Licensure

FROM: Executive Committee of the National Intern and Resident Matching Program

SUBJECT: NIRMP Policy on First-Year Appointments in Graduate Medical Education

The above stated policy as transmitted in the bulletin of June 18, 1970 has evoked a variety of responses requiring this additional clarifying statement.

The NIRMP Board of Directors regrets its inability to submit a plan to program directors and to solicit comments and suggestions before it became necessary to establish a policy for the 1971 matching program. An overriding consideration was the need to serve the interests of graduating medical students by a prompt policy determination on the mechanism by which first-year programs in graduate medical education not requiring prior internship were made available to them.

Because of the irregular timing of policy determinations of certain specialty boards, and because of the certainty of additional such changes in the near future, the Board was of the unanimous opinion that to have delayed a policy decision for another year might have compromised permanently the effectiveness of the matching program. This would have been a grave disservice to medical students as well as to program directors.

Many program directors in the six identified specialties may be uncertain as to the relative proportion of graduating medical students and those completing internships who will have an interest in the program. It was therefore in a deliberate attempt to assist program directors that the option was established of listing some, all, or none of the first-year positions as available to graduating medical students, just as if they were internships.

The following statements clarify the options available to program directors regarding their response to the July 15 deadline:

1. Program directors may defer decision and not ask for a code number in the 1970-71 Directory. After they have had an opportunity to determine the interest of graduating medical students during the Fall months of 1970, they may then request participation in the matching program and a code number, specifying the number of positions to be matched.

2. Program directors may request a code number by July 15 for publication in the Directory, including only those positions which they feel will probably be filled from the pool of graduating medical students, reserving the remainder to be filled by those completing internships. After they have determined student interest during the Fall, they may then request increase or decrease in the number of positions to which graduating medical students will be matched.

Requests for participation in the matching program as outlined in either of the above two examples must be received in writing at the NIRMP office not later than December 1, 1970.

Immediately after January 1, 1971, a supplementary list of newly-approved internships will be published and circulated. To this list will be added those additional first-year programs in the six specified specialties, with their code numbers, which have been requested as in example #1 above. This list will not include those programs already listed with code numbers in the Directory, even though the number of positions requested for matching have been changed as in #2 above.

Any requests for further changes in matching complement after December 1, 1970 will be accepted only upon payment of a special \$25.00 processing fee. No such changes can be accepted after March 1, 1971.

The situation for 1971-72 will undoubtedly be different in some respects. Every effort will be made to work with the various groups concerned to establish uniform policies regarding internship requirements.

It is the firm belief of the NIRMP Board of Directors that the rapidity of change in the nature and duration of graduate medical education makes mandatory the preservation of an orderly mechanism for entry of graduating medical students voluntarily into first-year graduate programs of their choice. Without such an orderly procedure, the situation may revert to the chaotic state that existed before the matching plan was instituted.

The Board welcomes any comments or suggestions you wish to provide for its consideration in modifying the procedure for the 1972 matching program. If further clarification is needed, please contact John C. Nunemaker, M.D. at either 328-9505 in Evanston or 527-1500 in Chicago.

July 13, 1970

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

2530 RIDGE AVENUE
EVANSTON ILLINOIS 60201

EVANSTON 312-328-9505
312-328-9506

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Executive Secretary

IMPORTANT BULLETIN

TO: All Hospitals with Approved Internships and Residencies
ATTENTION: Hospital Administrator and Director of Medical Education
SUBJECT: NIRMP Policy on First-Year Appointments in Graduate Medical

Attached to this letter is the policy statement approved by the Board of Directors of the National Intern and Resident Matching Program at its annual meeting held on May 28, 1970.

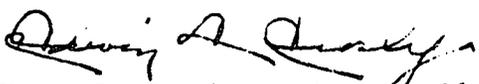
This policy position was established in response to the widespread concern and requests for guidance from program directors and medical school deans.

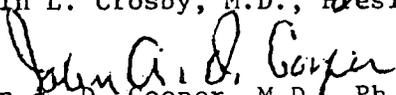
Also attached to this letter are copies of the Amended Hospital Agreement with instructions for the guidance of program directors who may or may not wish to revise their list of programs to be offered through the NIRMP.

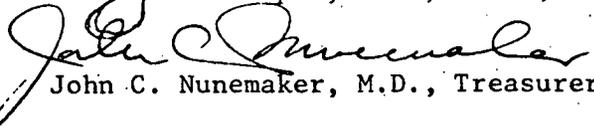
It is imperative that hospitals return the Amended Hospital Agreement promptly in order to assure the listing of any revisions in the AMA DIRECTORY OF APPROVED INTERNSHIPS AND RESIDENCIES 1970-71.

The deadline for receipt of the revised hospital agreement is July 15, 1970. The forms should be returned to:

Department of Graduate Medical Education
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610


Edwin L. Crosby, M.D., President


John A. D. Cooper, M.D., Ph.D., Vice President


John C. Nunemaker, M.D., Treasurer

June 18, 1970

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

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EVANSTON ILLINOIS 60201
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NIRMP POLICY ON FIRST-YEAR APPOINTMENTS IN GRADUATE MEDICAL EDUCATION

In 1950, the National Intern Matching Program was devised to bring order out of the chaos which had resulted from the confusion and unwarranted competition associated with intern appointments in the post-World War II period. This program provided a coordinated system for appointment of interns and was intended to serve the best interests of both interns and hospitals.

This program has operated successfully on a voluntary basis for 20 years, and the participation of graduating medical students and hospitals has been maintained at approximately 98%.

Once again, confusion and unwarranted competition is developing, partly as a result of the evolution of the internship year into the continuum of graduate medical education, but mainly because of the policies of certain specialty boards in deleting the requirement for an internship as a prerequisite for the required residency years.

As a result, graduating medical students are being subjected to undesirable pressures to withdraw from the matching program in order to accept appointments directly to residencies in those specialties which do not require a prior internship.

Questionnaire replies from both interns and residents during 1969 indicated that they were strongly in favor of continuing a matching program for the internship year. Furthermore, medical students, as represented by the SAMA, have always supported the matching program.

It is the conviction of the Board of Directors of the NIRMP that elimination of the internship requirement by some specialty boards is a sincere effort to shorten the total span of graduate medical education; therefore, such actions are not interpreted as attempts to obtain unfair advantage by inducing medical students to ignore the protection afforded them by participation in the matching program.

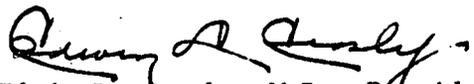
Accordingly, the Board of Directors of the National Intern and Resident Matching Program, recognizing that the distinction between internship and first-year residency is oftentimes only semantic, believes that it is in the continued best interest of both hospitals and graduating medical students for appointments to the first year of graduate medical education to be coordinated through the existing matching program mechanism.

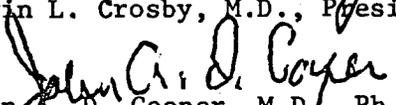
The policy for the National Intern and Resident Matching Program for 1971-72 will be as follows:

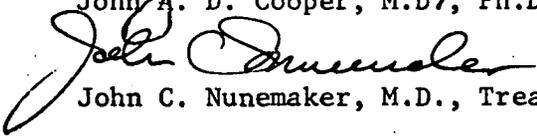
1. Each hospital participating in the NIRMP must agree to make all of its first-year programs in graduate medical education available through the NIRMP. A participating hospital may not withhold any of the approved programs to which graduating medical students are eligible to apply.
2. The Hospital Agreement will be amended to provide that each first-year program in graduate medical education, whether identified as an internship, first-year residency, family practice program, or by other designation, will be offered through the NIRMP.
3. NIRMP Code Numbers will be assigned to all first-year programs to which graduating medical students are eligible to apply, and students should include all such programs in their confidential rank order lists.

This includes first-year residencies in the specialties of family practice, neurology, obstetrics-gynecology, ophthalmology, pathology, and psychiatry, at the present time.

4. This policy does not apply to those separate residency matching programs in specialty fields where internships or other graduate medical education programs are required prior to an appointment to a residency.


Edwin L. Crosby, M.D., President


John A. D. Cooper, M.D., Ph.D., Vice President


John C. Nunemaker, M.D., Treasurer

June 18, 1970

INSTRUCTIONS FOR COMPLETING THE AMENDED HOSPITAL AGREEMENT

Although there are six specialties in which internship is no longer required as an eligibility basis for specialty board certification, there is no requirement that program directors in those specialties must abandon their own internship requirements. In fact, some program directors in those fields have indicated that they will continue to recommend clinical internships to candidates for appointment to first-year residency positions.

For instance, if the director of a residency program in neurology feels graduating medical students should complete an internship prior to being appointed to his program as first-year residents in neurology, then he should leave blank that space on the agreement where he would request a code number. However, if he offers six first-year residency appointments in neurology but wishes to offer only two of them to graduating medical students, then he should indicate opposite "neurology" the number of positions to be filled through NIRMP and request a code number. The directory will still list the total appointments available.

This Amended Hospital Agreement is for the sole purpose of modifying the former Hospital Agreement so that code numbers and positions available through the NIRMP for the six specialties listed can be added to the AMA DIRECTORY OF APPROVED INTERNSHIPS AND RESIDENCIES 1970-71. (Where two or more hospitals participate in an integrated residency and are listed in the Directory by indentation beneath a program heading, the director of the over-all integrated program should include a special letter identifying all of the hospitals involved and requesting a single code number to be listed opposite the program heading.)

THIS REVISED HOSPITAL AGREEMENT IS NOT TO BE USED TO REVISE THE NUMBER OF RESIDENT POSITIONS TO BE LISTED IN THE DIRECTORY IN FIELDS OTHER THAN THOSE IN WHICH FIRST-YEAR POSITIONS ARE AVAILABLE TO GRADUATING MEDICAL STUDENTS. CHANGES CANNOT BE ACCEPTED IN THE NUMBERS OF AVAILABLE INTERNSHIP POSITIONS ALREADY REQUESTED ON THE FORMER HOSPITAL AGREEMENT.

ALL AMENDED HOSPITAL AGREEMENTS SHOULD BE RETURNED EVEN THOUGH THE HOSPITAL DOES NOT WISH TO MAKE CHANGES IN THE FORMER AGREEMENT.

If a hospital wishes to offer first-year residency appointments to graduating medical students but does not wish them to be available through the NIRMP, then it must withdraw from the NIRMP altogether and must offer its internships outside the NIRMP also.

June 18, 1970

AMENDED HOSPITAL AGREEMENT

For Appointments to First-Year Graduate Medical Education Positions
Starting between April 1 and December 31, 1971

On behalf of the hospital listed below, this is confirmation of my understanding of the NIRMP Policy, as announced in the letter and attachments dated June 18, 1970, with specific reference to including in the NIRMP all of this hospital's first-year programs in graduate medical education.

1. This hospital wishes to continue its participation in the NIRMP by listing all of its approved internship programs, but does not wish to have matching code numbers assigned to its approved first-year residencies, since graduating medical students are not eligible for such appointments in this hospital.

2. This hospital wishes to participate in the NIRMP by listing all of its approved internship programs plus its approved first-year residencies to which graduating medical students are eligible for appointment, as specified below:

<u>Specialty</u>	<u>No. of Positions to be offered through NIRMP</u>	<u>(Office Use Only) NIRMP CODE</u>
FAMILY PRACTICE	_____	_____
NEUROLOGY	_____	_____
OBSTETRICS-GYNECOLOGY	_____	_____
OPHTHALMOLOGY	_____	_____
PATHOLOGY	_____	_____
PSYCHIATRY	_____	_____

3. This hospital does not offer approved internships but is approved, independently, for residency programs in those specialties listed below to which graduating medical students are eligible for appointment to first-year positions. Code numbers are requested in those specialties listed below:

<u>Specialty</u>	<u>No. of Positions to be offered through NIRMP</u>	<u>(Office Use Only) NIRMP CODE</u>
FAMILY PRACTICE	_____	_____
NEUROLOGY	_____	_____
OBSTETRICS-GYNECOLOGY	_____	_____
OPHTHALMOLOGY	_____	_____
PATHOLOGY	_____	_____
PSYCHIATRY	_____	_____

4. This hospital does not wish to continue its participation in NIRMP.

NAME OF HOSPITAL

NAME POSITION

STREET ADDRESS

SIGNATURE

CITY STATE ZIP

DATE

June 18, 1970

COLLEGE OF HUMAN MEDICINE • OFFICE OF THE DEAN • GILTNER HALL

July 7, 1970

MEMORANDUM

TO: Deans of New and Developing Medical Schools

FROM: Dean Andrew D. Hunt

SUBJECT: Retreat held at Schuss Mountain, Michigan, June 18-20, 1970

In attendance were Monty and Mrs. DuVal, Sherman and Mrs. Kupfer, Dick and Mrs. Moy, Bob and Mrs. Page, Lamar and Mrs. Soutter, Bob and Mrs. Stone, Donn Smith and Pierre Galletti.

The meeting was conducted in an informal way, with the distributed agenda being roughly followed. While, in general, the meeting took the form of general "group process" with elements of psychotherapeutic benefit, general consensus was reached on five points which, we feel should be transmitted to the AAMC Executive Council.

These were as follows:

1. Two-year medical schools seem no longer to be viable entities. The old concept of two years of basic science taught qua science, followed by two years of clinical medicine has long gone. The majority of the new two-year schools have either transformed themselves into complete degree-granting medical schools, or are struggling to accomplish this transformation. Hence, we strongly recommend that institutions contemplating the development of medical schools be urged not to embark upon establishment of two-year schools. Furthermore, we feel that the Liaison Committee should consider taking action which would strongly discourage the formation of new two-year medical schools.
2. Special Improvement Grant mechanisms are unsuited to and usually inappropriate for medical schools, largely because of the decisions which have been made concerning priorities. Indeed, the failure rate of new and developing schools to obtain Special Project Grant funding leads us to feel that further efforts in this direction may well be fruitless.

The Basic Improvement Grant, on the other hand, is exceedingly useful. It is our feeling, furthermore, that the Basic Improvement Grant program could be developed so that its application is universal and applicable to all medical schools, especially if certain flexibility can be built into it. Hence, it was the strong consensus of the group that the Special Improvement Grant Program might well be abolished, and superseded by an expanded, more uniformly developed Basic Improvement Program.

July 7, 1970

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3. The group was most concerned about the current changes developing in mechanisms for financing university hospitals, in which most such funding might come under the aegis of the Hill-Burton legislation.

The group was especially concerned about the Hill-Burton formulas for funding, which, generally, are based exclusively on bed requirements of communities. The group feels that, in the case of community hospitals being used for teaching through affiliations with medical schools, such funds could be exceedingly well used on construction of facilities other than beds, such as classroom space, libraries, laboratories, development of comprehensive out-patient facilities and the like.

The consensus of the group, then, was that medical schools and their affiliated hospitals obtain permission to bypass in some way the current Hill-Burton formulas and encourage expansion of community hospitals in a way which contributes to their educational programs, exclusive of the mathematics of beds.

4. Great interest was shown in the phenomenon of medical school maturation. Problems confronted by the dean of a new medical school are almost totally different from those for which he must be prepared once the school has stabilized in size, and entered the ranks of established institutions. History seems to indicate that the individual who is a successful dean of a school in its earliest years, may need to yield to others as the institution becomes more mature. It was the consensus of the group that much information has not accrued about such matters as the process of maturation and ways in which anticipated changes can be planned.

Hence, it was the sense of the group that a two-day seminar on the maturation of medical schools might be a most worthwhile project for the future. This will be discussed at the meeting of the deans of new and developing schools at the AAMC meeting in Los Angeles next fall.

5. The group felt that new medical schools should perforce develop individualized arrangements and agreements with community hospitals in which educational programs occur. There is, indeed, much room for innovation and experimentation in the field of community-based medical education. Furthermore, the process through which accommodations are reached between community hospital staffs and medical school faculties vary greatly both in style and in time required for success. It was the feeling of the group that at times the Liaison Committee site visiting teams seem somewhat rigid, establishing requirements and standards for affiliating agreements which are compatible with the accreditation process rather than with existing community variables.

The group, therefore, enters a plea to the Liaison Committee that it be somewhat more flexible and understanding of the issues involved in new medical schools working with their communities, so that they may be judged by their goals and eventual probabilities rather than by the actual state of affairs at the time of the accreditation visit.

While these points need further discussion and elaboration at the Los Angeles meeting, the group felt that they should be transmitted to John Cooper now so that he might be aware of our thinking.

Deans of New and Developing Medical Schools

July 7, 1970

Page three

Hence, a copy of this memorandum is being sent to him. Also, for information, I am taking the liberty of sending a copy to Bill Ruhe, in the Office of the Council of Medical Education of the AMA.

It was, we felt a useful and pleasant meeting, and the idea of an annual event of this kind seemed popular. Donn Smith indicated his willingness to host a similar event in Florida early next spring. This, also, will be discussed in Los Angeles.

6. Bob Stone distributed some materials connected with the issue of medical service plans. I attach copies of the materials for those who did not attend the meeting.

ADH:ck

Attachments

