AGENDA

COD Administrative Board

September 14, 1972
AAMC Conference Room
Washington, D.C.
9:00 AM - 4:00 PM

I. Call to Order - 9:00 AM

II. Approval of Minutes, Meeting of May 18, 1972

III. Organization of Faculty Representatives

IV. Report of the Ad Hoc Committee to Consider Medical School Admissions Problems

V. Item Referred from the AAMC Executive Council: "Resolutions on the Representative of Basic and Clinical Scientists in Academic Health Centers"

VI. Council of Deans 1973 Spring Meeting

VII. Election of Institutional Members

INFORMATION ITEMS

I. Report of Follow-Up on COD Phoenix Resolutions

II. COD Annual Meeting Program

III. Schedule of Regional Meetings

IV. Health Services Advisory Committee Activities
A. Minutes of May 31 Meeting
B. HMO Development in Academic Medical Centers

V. Committee on Graduate Medical Education

VI. RMP-CHP Committee-Minutes of June 15 Meeting

VII. Draft Agenda for Council of Academic Societies Workshop on Individualized Medical Education

VIII. Summary of Invited Workshop on Modification of Medical College Admission Test Program

IX. Status Report on the Longitudianal Study of Medical School Students

X. Report on Recent Internal Revenue Service Rulings Regarding Taxability of Research Fellowship Stipends

INFORMATION ITEMS
(continued)

XI. Report on American Board of Medical Specialties Action Regarding the NIRMP

XII. Legislation Report

A. Chart on Current Status of Legislation of Interest to the AAMC
B. Testimony of the AAMC
1. Statement before the Republican Platform Committee
2. Statement on Legislation to Support Training in Family Medicine, to Provide Assistance for Medical Libraries and to Support Training of Public Health Personnel
3. Statement on Legislation to Improve Medical Emergency Transportation and Services
4. Statement on Legislation to Improve the Health Care Delivery System
5. Statement on Certain Appropriations for the Department of Health Education and Welfare, Fiscal Year '73

XIII. Sex Discrimination and Higher Education

A. Summary of Provisions in the Higher Education Act 1972
B. HEW Contract Compliance - Major Concerns of Institutions

XIV. Faculty Unionization - Recent Developments

STAFF REPORTS

-Management Advancement Program

DISCUSSION ITEMS

-Executive Council Agenda Items of Particular Interest to the COD

A. Liaison Committee Documents
1. Programs in the Basic Medical Sciences
2. Essentials for Education of the Physician's Assistant

B. The Establishment of New Groups

C. The Committee on Financing of Medical Education

D. Policy Statement of the AAMC on the Protection of Human Subjects

E. Dual Payments to House Staff

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

May 18, 1972
12 noon - 4:00 pm
AAMC Headquarters
Washington, D.C.

Present:

(Board Members)

Carleton B. Chapman, M.D.
J. Robert Buchanan, M.D.
Clifford G. Grulee, M.D. - 10:00 A.M.
William F. Maloney, M.D.
William Mayer, M.D. - YES
Harold C. Wiggers, Ph.D. - NO

(Staff)

John A. D. Cooper, M.D.
Janice Browning
Joseph A. Keyes
Joseph Murtaugh
James R. Schofield, M.D.
August Swanson, M.D.
Bart Waldman
Marjorie P. Wilson, M.D.

Absent:

Ralph J. Cazort, M.D.
Sherman Mellinkoff, M.D.
Emanuel Papper, M.D.

Guest:

Samuel L. Clark, Jr., M.D.

I. Call to Order

Dr. William Mayer called the meeting to order shortly after noon and presided until Dr. Chapman arrived.

II. Minutes of the Previous Meeting

The minutes of the February 3, 1972 COD Administrative Board were approved as circulated in the Agenda Book.

III. Admissions Problems

Dr. Wilson reported that the May 10, 1972 meeting on Medical School Admissions Problems had been cancelled and would soon be rescheduled.* Board members indicated their interest and concern with the problems to be addressed. Those who had seen the packet of materials judged

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* The meeting was subsequently rescheduled for July 11; each member of the Administrative Board was invited to participate. The report of that meeting appears in the Agenda Book for the September 14, 1972 meeting of the Administrative Board.

that the Rosenberg article, particularly his suggestions regarding the more limited use of the interview in the selection process, would stimulate considerable controversy among admissions officers.

IV. Guidelines for Sub-Council Organizations

At its previous meeting, the Board reviewed and approved in principle a proposed organizational structure for Sub-Council Activities; it requested that the Executive Council defer final action on the proposal until the implications of the proposal and its impact on existing groups could be further examined.

At the May 18, 1972 meeting, the Board was presented with a revised draft of the document Guidelines for Sub-Council Organizations for its review. A number of changes had been made from the previous version. The distinction between Groups and Sections was eliminated, all such organizations to be known as Groups. This category was redefined so as to be more inclusive and the relationship between the AAMC staff and the activities of the Groups was emphasized.

The Board was sensitive to problems of communication and coordination and was concerned that the lack of an organizational relationship between the Groups and the Councils would exacerbate these problems. Further, it believed that the rules and regulations should be subject to the approval of the Executive Council as well as the Association President. Thus the Board suggested several amendments to the Guidelines and took the following action:

ACTION: The Administrative Board unanimously endorses the Guidelines for Sub-Council Organizations subject to the following suggested amendments:

B. Groups

2. All Group activities shall be under the general direction of the AAMC President or his designee from the Association staff *and shall relate to the appropriate Council(s) as determined by the Executive Council.*

3. Groups may develop rules and regulations subject to the approval of the AAMC President *and the Executive Council.*

5. The activities shall be reported periodically to the *(delete Executive)* Council*(s) designated under B 2 above.*

V. Discussion of the Phoenix Meeting

The Administrative Board reviewed the two motions passed at the Phoenix Meeting of the Council of Deans on April 22, 1972, as presented in the Agenda Book. The first motion is related to assessing the quality of the educational process, the second to assessing the quality of health services. There was considerable discussion regarding the

the intent of the Council with respect to each motion.

ACTION: After considering the remarks leading to their passage at the Phoenix Meeting, the Administrative agreed to the following formulation of the motions:

1. The Council of Deans recommends that the AAMC undertake a major study of undergraduate and graduate medical education programs, a study which has at its focus the definition of the quality of their product in quantifiable terms. This should include: (A) The development of standards and priorities by which the quality of educational programs may be assessed; and (B) The indentification of the relationship between the performance of the physician and his educational experience.

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

VI. Faculty Representation

Dr. Chapman indicated his interest in assuring that each dean had carefully assessed the issue of additional faculty participation in the governance of the AAMC and had sought the advice of his own faculty with respect to this question. He suggested that prior to further discussion of the matter at open meetings, some means should be found by which to stimulate an assessment of the level of commitment to the concept at local institutions. Various approaches were considered. These included a questionnaire to all faculty members, a questionnaire to the chairmen of the faculty senate and executive faculty at each school, and a letter to the dean at each school requesting that he query the faculty and report his findings. It was agreed that the Chairman should write to each dean describing the history of the debate and the specific proposal forwarded to the COD by the Executive Council. The letter would request that the dean respond with his own assessment of the proposal as well as that of his general faculty and his executive faculty.*

VII. Planning Future COD Meetings

1. Annual Meeting

The Board reviwed and approved the tentative schedule of COD

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*The letter was sent on June 1, 1972. The September 14, 1972 Agenda Book contains an analysis of the responses received.

activities at the AAMC Annual Meeting. These include a business meeting of the Council from 2:00 pm to 5:00 pm on Friday, November 3, and a joint-program meeting with the Council of Academic Societies on Sunday morning from 9:00 am to 12:30 pm. In addition the Board received a report that recent discussions with the officers of the Veterans Administration Department of Medicine and Surgery had resulted in a proposal that VA hospital directors and central staff meet with the Council at an appropriate time in conjunction with the Annual Meeting. Such a meeting was first suggested at the VA-AAMC Liaison Committee Retreat held in the spring of 1971. A number of individual deans and the deans of the southern region as a group had endorsed the concept of such a meeting and had urged that it be held as soon as feasible. The Board approved the proposal and set the meeting for Thursday, November 2, from 4:00 pm to 6:00 pm. In addition, an Administrative Board luncheon meeting is scheduled for noon on Friday, November 3.

Thus, the COD calendar of meetings in conjunction with the AAMC Annual Meeting is set as follows:

Thursday, November 2, 1972
4:00 pm - 6:00 pm Council of Deans/Veterans Administration Joint Session*

Friday, November 3, 1972
(Noon to 1:30 pm Administrative Board Luncheon Meeting
2:00 pm - 5:00 pm COD Business Meeting

Sunday, November 5, 1972
9:00 am - 12:30 pm COD/CAS Joint Meeting*

*Programs for these meetings appear as Appendix I & II to these minutes

2. Spring Meeting

Dates for next year's spring meeting of the Council were discussed. The Board suggested that with the expected elimination of the mid-year meeting of the Association which had been held in conjunction with th AMA Congress on Medical Education, the date of the Spring COD Meeting should be moved to sometime during the last two weeks of February or the first two weeks of March.**

The Board reviewed the list of suggested topics for the forthcoming Spring Meeting suggested in the responses to the questionnaire addressed to those in attendance at the Phoenix meeting. Additional themes were suggested including one which would deal with current criticisms of higher education as reflected in the Newman Task Force Report on Higher Education and the trends which these criticisms might portend. The Board requested that the staff obtain

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**Subsequently, arrangements have been made with the Hotel Palacio del Rio, San Antonio, Texas, for the period March 7-10, 1973.

a copy of the report for each member. No decisions on the theme were made. The staff was requested to develop a preliminary proposal in consultation with the Chairman and Chairman-Elect for consideration at the next meeting of the Board.

3. Proposed Workshop on Individualizing Curricula

The Council of Academic Societies Administrative Board has proposed that the Association sponsor a meeting in the spring of 1973 to consider individualization of the medical school curricula. This was envisioned as a workshop conducted under the aegis of the CAS or as a joint undertaking of the CAS and the COD. The Board reviewed a prospectus for the meeting prepared by the CAS chairman. It agreed that such a meeting would be a valuable enterprise, indicated its support for the project, and suggested that each dean be offered the opportunity to attend or send a representative. However, because the Phoenix meeting appeared to be a promising precedent for a separate spring meeting of the deans, the Board declined the invitation to jointly sponsor such a workshop in lieu of a meeting of the Council of Deans.

VIII. New Business

A. Faculty Directory

A draft memorandum was distributed requesting the views of the COD and CAS as to the utility of utilizing the data collected in the Faculty Roster project to publish a directory of persons holding faculty appointments at medical schools. The Board's view was sought prior to any further distribution of the memorandum. The Board generally agreed that such a directory might prove valuable, but suggest that it would be feasible only upon the resolution of the problems being encountered in the Roster project. After a short review of efforts underway to simplify the data collection effort and to increase the return to the schools, the Board gave mild support to the directory project on condition that the Roster problems were first overcome.

B. A closed executive session was called to discuss the proposed AAMC budget for the coming year.

C. AAMC Testimony

Several deans had communicated their disagreement with the position the AAMC proposed to take on several issues in testimony to be presented before Congressional committees. It was suggested that the method used in developing and clearing testimony be clearly set out in a memorandum to the members of the Assembly. This has subsequently been accomphished. (See Memorandum #72-31, Attachment III)

D. Additional Items of New Business

Several additional items which the Board had intended to consider were not reached because of a lack of time. These included:

-A resolution of the CAS relating to the role of basic medical science in medical education.

-LCME Guidelines for the accreditation of programs in basic medical science
-Issues relating to regional medical programs
-A study proposed by the Committee on Financing relating to the compensation of clinical facilities.

IX. Information Items

The Board noted the information items in the agenda book and heard a brief report on the progress of the Management Advancement Program.

X. Adjournment

The meeting was adjourned at 4:00 pm.

ATTACHMENT I

Joint Session of
The Council of Deans
with
Officers of the Veterans Administration,
Department of Medicine and Surgery,
and Veterans Administration Hospital Directors

Thursday, November 2

THEME: The VA-Medical School Relationship: Current Concepts and New Directions

I. Selection and Appointment of Hospital Directors, Chiefs of Staff, and Service Chiefs

II. Extension of VA-Educational Programs

- New Medical Schools
- New Support for Existing Programs
  - -Medical School Expansion on Clinical Campus
  - -Modernization of Facilities
- Area Health Education Centers

III. New VA Programs and Mechanisms of Health Care Delivery

- Ambulatory Care
- Extension of Care to Dependents
- VA as a Community Health Resource
- VA Participation in HMO Arrangements
- The Contract Mechanism - Its Use and Limitations

Note: Briefing Sheets will be provided on current legislation of interest and on the VA FY 73 budget.

7-10-72

COD/CAS JOINT MEETING
Sunday, November 5, 1972
Miami Beach, Florida

"Colleges and Medical Schools - Approaches to Accomplishing Their Joint Mission"

9:00 am	-	Introduction
9:05 am	-	"Human Biology" - A New Undergraduate Major for the Liberal Arts
9:25 am	-	Discussion
9:40 am	-	Direct Alignments of College Programs with Medical Schools
10:00 am	-	Discussion
10:15 am	-	Coffee
10:30 am	-	Medical School Academic Entrance Requirements and the Realities of the Usual College Curriculum
10:50 am	-	Discussion
11:05 am	-	Experiences with A.B.-M.D. Programs Which Select Students for Medicine from High School or the First College Year
11:25 am	-	Discussion
11:40 am	-	Experiences With Encouraging Medical Students to Take Courses for Credit in Other Colleges in the University
12:00 N	-	Discussion
12:15 pm	-	Adjourn

ATTACHMENT III

ASSSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #72-31 June 9, 1972

TO: Voting Members of the Assembly

FROM: John A. D. Cooper, M.D., President

SUBJECT: PREPARATION OF ASSOCIATION TESTIMONY

There have been a number of requests for information recently on the general process through which testimony presented by the Association of American Medical Colleges before Congressional committees is prepared and approved. This Memorandum is designed to explain that process in terms of legislative analysis, policy formulation, and witness selection.

1. Legislative Analysis. The staff of the Association maintains a continuing review of legislation as it is introduced into Congress for its impact on the constituency of the Association. Legislation affecting the Association is subjected to detailed review in anticipation of the need to comment upon it. The Association staff and, depending on the complexity and urgency of the issue, special ad hoc constituent groups analyze the key legislative proposals in terms of their operational nature, their relationship to existing programs and legislation, and their technical feasibility and desirability. The results of this analysis comprise a major part of Association testimony.

2. Policy Formulation. All testimony of the Association is set in the context of Association statements of policy. Those statements are positions which have received the favorable consideration of the Executive Council and/or the Assembly, depending on the time factor involved. The Association staff and the appropriate ad hoc constituent group, having analyzed the legislation, recommend the policy statement to the governing bodies for adoption.

In those instances when the press of time does not permit the consideration of a statement of policy, an outline or a complete draft of the proposed testimony is distributed to members of the Executive Council or the Assembly for comment prior to presentation. However, even this procedure requires a period of several weeks for response and the Congress is sometimes most uncooperative in providing this luxury. Therefore, under the most severe conditions of urgency and to avert bureaucratic paralysis, the AAMC President will attempt to contact by telephone the Association's Executive Committee (AAMC Chairman and Chairman-Elect, three Council Chairmen) and, having received the concurrence of those with whom he has conferred, the President will approve the testimony for presentation.

3. Witness Selection. The process of selecting the Association witness is basically derived by choosing from among the Association's constituency the individual having the most expert command of the subject matter or a special relationship to the Chairman or ranking members of the committee. The President and the Chairman of the Association must determine if the legislative issue warrants the appearance of an out-of-town constituent as well as who would best represent the AAMC. In situations where such an individual is unavailable or the use of his time unwarranted, either the President or Chairman of the Association will present the testimony.

III. ORGANIZATION OF FACULTY REPRESENTATIVES

The Administrative Board of the COD has before it the question of the appropriate next steps to be undertaken to resolve within the Council of Deans, the issue of faculty participation in the affairs of the AAMC. The latest action of the COD was to defer resolution until there had been adequate regional consideration of the OFR proposal forwarded by the Executive Council for COD and CAS deliberation, setting the November COD meeting as the outside time limit for such determination. Facotrs relevant to the Board's conclusion include the following:

1. No region has considered the matter formally subsequent to the February COD meeting. Three Regional Meetings are currently scheduled to be held prior to the November meeting.

2. The letter from the COD Chairman elicited responses from 52 schools. A substantial proportion of the responses included either no opinion or an ambivalent response from one or several segments of the school.

3. A plurality of the total responses and of the responses of each segment queried--excepting the general faculty whose plurality was in favor--opposed the proposal.

4. Thirteen of the 52 responses indicated a strong feeling among the faculty that an independent Council of Faculty would be more appropriate than an Organization of Faculty Representatives related to the Council of Deans.

5. At its February 1972 meeting, the CAS voted to "establish" a Council of Faculties within the AAMC, and defeated a motion proposing an OFR.

6. At its May 1971 meeting, the COD voted to recommend to the Assembly that the Association "at this time not consider any further mechanisms for representation of faculties in the national association and that existing mechanisms be strengthened and utilized to increase the input of the general faculty in the AAMC."

It is clear therefore that as a result of extended consideration of the issue within the AAMC, no clear consensus has emerged.

The Administrative Board would appear to have the following alternative courses of action open to it:

1. Refer the OFR proposal to the Regions for consideration and to the November COD meeting for final determination.

2. Endorse the Council of Faculty proposal adopted by the CAS and recommend its adoption by the COD after regional consideration.

3. Develop an alternative proposal for regional and COD consideration.

4. Recommend further delay to allow for additional study.

The first alternative is consistent with the February COD resolution and does not require the Administrative Board to take a position on the merits of the issue. Recognizing that no consensus exists, it probably would force a close and potentially devisive vote.

The other alternatives represent an effort to reach a consensus which is not in sight at the present and probably contain the risk of further frustration over the extended lack of resolution.

RECOMMENDATION: That the COD Administrative Board adopt alternative number one above.

History of Faculty Debate

1965 - Coggeshall Committee recommended a broadened constituency in order to provide greater opportunity for the academic medical community to participate in the governance of the Association.

1966 - June Executive Council Meeting approved the establishment of a Council of Faculty and a Council of Academic Societies.

1966 - July -- At the meeting of the Institutional Membership, it was decided that the faculty could make its most meaningful contributions at the regional level or through the various academic societies and so the motion to establish a Council of Faculties was defeated. It was at this meeting that the decision was made to establish the Council of Academic Societies.

1967 - January -- Council of Academic Societies held its first organizational meeting.

1968 - Discussion on Organization of Faculties but no action taken.

1970 - October/November Annual Meeting of the AAMC. It was recommended that an Organization of Faculty ('institutional') Representatives related to the Council of Deans be developed. No action was taken.

1971 - February -- At the Assembly meeting there was a resolution passed that there be an organization of the faculties of the member institutions represented in the governance of the Association. Following this resolution recommendations were solicited. Much discussion followed but no decisions were reached.

May COD meeting approved a statement urging no further mechanisms of representation of the faculties in the national association.

June Executive Council received recommendations from the CAS on possible mechanisms to give faculty broader representation in CAS. It was decided that no organizational or bylaw changes were necessary.

September -- CAS Administrative Board passed a resolution to expand the CAS to include 2 representatives from the faculty of each institutional member. In agreement with this, CAS votes in the Assembly and on the Administrative Board were to be increased by elected faculty representatives. This resolution was then presented to a full meeting of the CAS.

At the September meeting of the Executive Council, a motion was adopted to recommend a retreat to further study the issue of faculty representation. Each Council was to be represented at the retreat.

October----The CAS tabled the resolution adopted by its Administrative Board in view of the upcoming December Retreat.

E.C. action missing

1972 - February---The CAS adopted a motion proposing the development of a Council of Faculty within the AAMC and defeated a motion to establish an Organization of Faculty Representatives.

February---The COD voted to delay action pending regional consideration of the OFR proposal. The final resolution on this matter was set to be made in the November meeting.

March----Dr. Carleton Chapman, Chairman of the Council of Deans, requested that there be no further discussion on this question until he had communicated with the individual deans to ascertain each school's sentiments on the issue.

The following are the results from Dr. Chapman's letter of request to individual schools for interest in this issue:

In response to Dr. Chapman's request for some data from the individual schools on the question of faculty organization, the following information was obtained:

52 Responding Schools

	Favor	Oppose	Ambivalent	No Answer
Deans	17	24	3	8
Executive Faculty	13	19	9	11
General Faculty	15	11	5	21
	45	54	17	40

Of the total favorable responses given:

37.7% were Deans
29.0% were Executive Faculty
33.3% were General Faculty

Of the voting schools, 36% voted as a block (Deans, Executive Faculty, and General Faculty all voting in the same manner).

REGIONAL BREAKDOWN

Western Region--9 schools voting--responses here based on yes-no answers only. Percentages are those favorable to OFR.

Deans	25%
Executive Faculty	0%
General Faculty	0%

REGIONAL BREAKDOWN

Southern Region--13 schools voting--responses are based on yes-no answers only. Percentages are those favorable to OFR.

Deans	27.3%
Executive Faculty	28.6%
General Faculty	75.0%

Midwestern, Great Plains Region--11 schools voting--responses are based on yes-no answers only. Percentages are those favorable to OFR.

Deans	70%
Executive Faculty	66.7%
General Faculty	66.7%

Northeastern Region--19 schools voting--responses are based on yes-no answers only. Percentages are those favorable to OFR.

Deans	41.7%
Executive Faculty	50.0%
General Faculty	55.5%

Less than 47% of the schools responded. Therefore the statistical information must be viewed as incomplete. Since a high percentage of those who responded were ambivalent or could give no final response, even the results obtained are statistically inconclusive.

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2. The letter from the COD Chairman elicited responses from 52 schools. A substantial proportion of the responses included either no opinion or an ambivalent response from one or several segments of the school.

3. A plurality of the total responses and of the responses of each segment queried--exception the general faculty whose plurality was in favor--opposed the proposal.

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The administrative Board would appear to have the following alternative courses of action open to it:

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3. Develop an alternative proposal for regional and COD consideration.

4. Recommend further delay to allow for additional study.

The first alternative is consistent with the February COD resolution and does not require the Administrative Board to take a position on the merits of the issue. Recognizing that no consensus exists, it probably would force a close and potentially devisive vote.

The other alternatives represent an effort to reach a consensus which is not in sight at the present and probably contain the risk of further frustration over the extended lack of resolution.

RECOMMENDATION: That the COD Administrative Board adopt alternative number one above.

ANALYSIS OF OFR PROPOSAL REACTIONS

SCHOOL	DEAN			EXECUTIVE FACULTY			GENERAL FACULTY			
	Favor(1)	Oppose(2)	ambivalent(3)	(1)	(2)	(3)	(1)	(2)	(3)	(4)**
UC-Los Angeles		X			X			X		
Yale University		X		**						X
Georgetown University				2	1	X(1)		X		
Univ. of Hawaii	X									X
Chicago Med. School		X		X			X			
Univ. of Iowa	X			X			X			
Univ. of Kentucky		X			X			X		
Amer. Univ. of Beirut	X			**						X
La. State Univ., N.O.		X		**						X
Harvard Univ.		X		**						X
Univ. of Missouri-Col	X			X			X			
Washington Univ.		X			X					X
Univ. of New Mex.		X			X			X		
Albert Einstein			X	**						X
SUNY-Stony Brook	X			X			X			
NY Univ. Med. Ctr.	X			X			X			
Mount Sinai		X			X			X		
Univ. of Rochester	X			X			X			
New York Med. College		X		**						X

**No Opportunity to Review

ANALYSIS OF OFR PROPOSAL REACTIONS

SCHOOL	DEAN			EXECUTIVE FACULTY			GENERAL FACULTY			
	Favor(1)	Oppose(2)	ambivalent(3)	(1)	(2)	(3)	(1)	(2)	(3)	(4)**
Cornell			X			X				X
Univ. of North Carolina	X			X			X			
Med. Col. Ohio-Toledo						X			X	
Univ. of Oklahoma		X			X					X
Med. Col. of Pa.Phil					X					
Univ. of Pittsburgh					X			X		
Vanderbilt U.	X			X			X			
Univ. of Tex.SW-Dallas	X					X	X			
Rush Med. Ctr.	X				X			X		
Univ. of Tex.Galveston		X			X			X		
Univ. of Tex.Houston		X			X					X
Univ. of Utah		X			X					
West Virginia		X			X					X
Univ. of Vermont		X			X					
Univ. of Washington		X			X					
Mayo Med. Sch.		X			X			X		
Southern Ill. Univ.	X			X			X			
Univ. of Arizona		X			X				X	
Michigan State U.	X			X						X

**No Opportunity to Review

ANALYSIS OF OFR PROPOSAL REACTIONS

SCHOOL	DEAN			EXECUTIVE FACULTY			GENERAL FACULTY			
	Favor(1)	Oppose(2)	ambivalent(3)	(1)	(2)	(3)	(1)	(2)	(3)	(4)**
Univ. of Missouri KC	X					X			X	
Albany Med. Col.		X			X					X
Univ. of Puerto Rico		X					X			
Univ. of Tex-San Antonio				X			X			
Univ. of Miami								X		
Stanford			X			X			X	
Upstate Med. Ctr NY	X			X			X			
Temple Univ.										X
Brown Univeristy		X				X				X
Univ. of Tennessee		X				X	X			
Univ. of Chicago	X			X						X
Univ. of S. Calif.	X				X					X
Tho. Jefferson Un.	,X			X			X			
Univ. of Miami	X					X			X	

**No Opportunity to Review

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

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

July 11, 1972

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

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

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

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

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

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

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

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

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

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

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

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

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

James R. Schofield, M.D.
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Director, Division of Academic Information
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Marjorie P. Wilson, M.D.
Director
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AAMC

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

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

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

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

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

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

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

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

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

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

The committee has developed a series of recommendations designed to

assist the schools in meeting these challenges.

Recommendations

DEFINE OBJECTIVES

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

ARTICULATE AND PUBLISH SELECTION FACTORS

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

CAREFULLY SELECT AND EDUCATE THE COMMITTEE

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

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

PROVIDE FULL-TIME SUPPORT

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

DESIGN PROCESS WITH COSTS IN MIND

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

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

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

A TRAVEL LOAN SUPPLEMENT FEASIBLE?

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

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

UNIFORM ACCEPTANCE DATES

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

DECISIONS SHOULD BE TIMELY MADE AND COMMUNICATED

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

POLICIES MUST ACCORD WITH THE PUBLIC TRUST

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

AMCAS USEFUL SUPPORT

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

ADVISORS DESERVE SUPPORT

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

HUMAN BIOLOGY AND HEALTH CAREERS

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

GSA IMPORTANT FORUM

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

A MATCHING PLAN FEASIBLE?

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

FURTHER STUDIES NECESSARY

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

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

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

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

8-14-72

Legal Considerations Related to Minority Group Recruitment and Admissions*

For too long there has been unusual and understandable concern for the legal and ethical problems relating to the admission of students to professional and graduate schools from minority and underprivileged communities. The purpose of this memorandum is to explore in as concise a fashion as possible prevailing legal attitudes and how several distinguished jurists view this irksome problem.

The Northeast Group on Student Affairs appointed a select committee to explore this issue and generally determine if existing mechanisms within the admissions process were tenable and consistent with the best interests of the school and the students affected. What about the "legality" of special committees on minority admission, recruitment and incentive programs, tutorial and academic support courses?

Any and all of these approaches have been tried and tested. Medical schools have used these and other techniques with some measurement of success but rarely with satisfaction. The message has been clear for some

*Reported to the Northeast GSA of the AAMC on June 22, 1972 by Martin S. Begun, Associate Dean, New York University School of Medicine.

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time - special efforts are to be made to equalize opportunities, to increase the numbers of physicians from minority groups, to enlarge the pool of doctors who will serve in depressed and physician-shortage areas and to generally broaden the realities of professional education for all who wish and are able to seek it.

There are questions of equity involved and serious doubts as to the appropriateness of all these good intentions in view of the long-established belief that the equal protection clause of the fourteenth amendment may restrict or inhibit this activity. Equally significant is the reality of legal challenge. Hardly a day goes by and certainly rarely a meeting of more than two medical school administrators that does not hear the refrains and whispered tones of self-doubt as to whether the "special efforts" are appropriate, legal and moral. Deans, school and university administrators, admissions officers, faculty, students, pre-medical advisors, parents, grandparents, politicians and the scores of friends and allies of prospective medical applicants have views which conveniently suit their needs or prejudices - but there is hardly anyone who does not hold a firm and resolute attitude on this most contentious subject except for those of us who may have the ultimate responsibility for developing and executing admissions policies. Ours is a world of paradox and uncertainty.

To the admissions office staff and Dean, it's the challenge of walking a tight rope. The angry, rejected applicant, the threatened and less often executed law suit, the countless inquiries and the awesome truth that urgent national need and historical deprivation necessitates a special response. With this as a backdrop, I viewed the problem from a legal standpoint. Self-doubt has always been endemic to the admissions process. Even when confronted by riches of academically talented youngsters there remains the element of choice and the inevitable query - why not me? Recognizing that choice and selection are constant admissions variables and what remains is the probability of a successful legal challenge. The heart of the matter is how the courts will treat the problem if and when presented with it, and their response which may not be consistent is the only tangible and dependable support available.

Five justices of the New York State Supreme Court were identified for consultation. Three judges spent a considerable amount of their time discussing their own and what they thought the courts ultimate response would be to a law suit similar to the one now before the Supreme Court of the State of Washington. The now recognized deFunis case which is a challenge to the University of

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Washington Law School on the question of the constitutionality of its admissions committee decision to deny a place to an applicant while granting admission to thirty students who are members of racial minorities with inferior academic qualifications. The plaintiff, Mr. deFunis, prevailed in the lower court and the law school was ordered to admit him. This case has now achieved national status and has conveniently found a niche in the sub-conscious of every admissions officer. Each of the judges selected for interview were given in advance the brief of amici curiae submitted to the appellate court in Washington as an introduction to the general problem.

Parenthetically, the justices were all mindful of the issues involved and anxious to discuss their philosophy in anticipation of having to rule on such a challenge. The approach and criteria used in choosing the judges were based on their availability, previous personal friendship, their political and social philosophies and care to ensure some divergance in viewpoint if possible. One judge is considered liberal, another moderate and the third conservative. Two additional judges were interviewed as a modified control but less intensively and ultimately substantiated the views and opinions which follow. All justices are from the First Department of the New York State Supreme Court which covers a jurisdiction of Manhattan

and the Bronx. Within the jurisdiction reside some four million inhabitants and several colleges and universities including five law schools, two dental and six medical schools, e.g. Einstein, Columbia, New York Medical College, Mount Sinai, Cornell and New York University.

The quid for the quo was that each jurist was to have his anonomity protected and a pledge was accordingly given. This is an understandable restraint which governs their conduct on matters which may ultimately come before them for adjudication. Therefore, the reader of this memo must rely on my notes, interpretive abilities and genuine concern for the issue at hand. This memorandum, therefore, by necessity lacks footnotes and other qualifying academic appurtenances. Nevertheless, the material and thoughts expressed are worthy of consideration and tend to cast a wholesome and positive light on the subject.

As a result of these interviews, the entire matter was reviewed not long ago at a conference of supreme court judges in the same judicial department and illustrates the concern of the bench for this particular issue.

The following sentiments have been marshalled as "items" for consideration and are put forth in a positive light to encourage medical schools to increase minority enrollment and to undertake appropriate support mechanisms.

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No priority or special significance is accorded to any one item and they are listed at random for equal consideration.

Item: The United States Supreme Court through various interpretations of the Constitution has not forbidden programs designed to increase access of minority groups to higher education. Further measures instituted to correct racial imbalance have been upheld as constitutional.

Item: Remedial and tutorial support programs in graduate and professional education is justified necessary and compelling.

Item: Preferential treatment of certain members of minority groups does not indicate exclusive reliance on race. Certain minority applicants are admitted with records of lower rank than some excluded non-minority candidates - the significance here can be too easily exaggerated. Race is not and should not be the sole and determinant factor. As a matter of fact, not all minority applicants are admitted - only those who after careful review of their records were deemed likely to succeed.

Item: Admissions Committees should consider many factors in making a decision - and factors which go beyond statistical and mathematical determinants are allowable and important. A committee which goes beyond consideration of scores, grades and rank order in aptitude tests seems eminently rational, since it seeks to "humanize" the process of selecting prospective members of the profession.

Item: Courts have generally shied away from upholding challenges to administrative rulings and tend not to override faculties of colleges and universities unless the act is obviously arbitrary and capricious. There is a long and continuing tradition to rely on the judgments of a faculty, especially when it concerns qualifications and standards of admission to a graduate or professional school.

Item: The best approach (and here there was absolute unanimity among all judges queried) is to spell out criteria and to broaden the number of factors which are involved in making a decision to admit or reject. Incidentally, medical schools are at a distinct advantage over other professional schools because of the general policy of requiring a personal interview

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before acceptance. This factor alone extends the judgment area beyond the mere consideration of scores and grade points as the sole criteria for admission.

Item: Experimentation in selecting a class is both desirable and permitted. The tendency to get away from rigid categories is also healthy so long as experimental and special programs are published and clearly defined as different from the normal or traditional practices.

Item: Admissions Committees clearly have the obligation and right to expand or restrict admissions criteria - although expansion of criteria is preferred and desirable. New and reasonable criteria may be included when considering applicants, i.e. the nature of societal and community needs viewed from a national as well as a local perspective; the school's surrounding neighborhood and its special requirements; a clear preference on the part of the candidate to pursue a specific community oriented experience upon completion of the course of study and the applicant's extra-curricular activities when examined against the immediate societal need and his long-range plan. No commitments by the student are necessary, just an expression of future interest and an honest belief that the applicant will most probably fulfill the commitment which

made his selection so compelling.

All of these factors and others make a rational basis for making a judgment other than on a score or grade comparison. Grades cannot in and of themselves accurately predict performance. Furthermore, grades as an exclusive determinant are being legitimately questioned.

Item: Establishing given percentages or quotas of minority students to be accepted in a class represents predictable problems. This should be avoided at all costs. It is possible to achieve the same results without giving the appearance of restricting portions of the class for designated groups.

Item: Medical schools may stimulate interest by creating mechanisms for recruitment, tutorial support and special preparatory courses so as to qualify and ultimately enroll minority students.

Item: Special committees or sub-committees of admissions entrusted with the unique problems of minority applicants are in fact legitimate and permissible.

Item: It is also appropriate to identify some students as career models or examples and to

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reassure other disadvantaged youths that emulation is possible and the "system" is penetrable.

Twelve items have been identified, all representing a consensus of judicial thought on the subject of minority recruitment and admissions. It would be foolhardy to rely on this memorandum as definitive law or as a cover for a multiplicity of actions not entirely consistent with local traditions, laws and judicial temperaments.

The purpose here is to convince the cautious, encourage the timid and fortify those who have engaged in useful and productive exploration. This memorandum and its information was not designed to be an admission office legal primer and should your institution be served with a subpoena, don't call the undersigned - call your lawyer.

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

August 11, 1972

V. ITEM REFERRED FROM THE AAMC EXECUTIVE COUNCIL JUN 12 1972

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

WASHINGTON: 202: 466-5175

June 7, 1972

MEMORANDUM

TO: Carleton B. Chapman, M.D.

FROM: John A. D. Cooper, M.D.

SUBJECT: AGENDA ITEM REFERRED TO COUNCIL OF DEANS

Russ Nelson has asked me to communicate to you the Resolution on the Interaction of Basic and Clinical Sciences which the Executive Council has referred to the Council of Deans for consideration at your next Administrative Board meeting. The Executive Council approved in principle the resolution stated on page 1 of the ACTIONS, and agreed that it would be considered by the Administrative Boards (other than CAS which initiated the resolution) and would be transmitted to the Liaison Committee on Medical Education.

LCME MINUTES

cc: Dr. Marjorie P. Wilson ✓

COTH Amendment.

RESOLUTION ON THE REPRESENTATION OF BASIC AND CLINICAL SCIENTISTS IN ACADEMIC HEALTH CENTERS

ACTION: The Administrative Board recommended adoption of the following resolution:

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

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

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

This resolution will be forwarded to the COD and COTH Administrative Boards for their consideration and will be presented for approval to the Council of Academic Societies in the fall.

Not incorporated

ACTION OF THE COTH ADMINISTRATIVE BOARD ON THE "RESOLUTION ON THE REPRESENTATION OF BASIC AND CLINICAL SCIENTISTS IN ACADEMIC HEALTH CENTERS"

The Administrative Board of the Council of Teaching Hospitals enthusiastically supports this resolution.

Participation by basic scientists in hospital activities has been increasing steadily. Their contribution to hospital laboratories and radiology departments have been long-lasting and of increasing importance. Newer developments in both diagnostic and therapeutic units, such as nuclear medicine, hemodialysis, patient monitoring and cardiac surgery, have involved substantial participation on the part of basic scientists. In addition, basic scientists play an essential role in the function of committees which monitor certain professional activities of hospitals, such as the Infections Committee, the Radiation Safety Committee, and the Committee on Human Investigations.

Since the teaching hospital will gain in increased capability of its clinical, teaching, and investigative functions through further integration of the basic medical scientists into the hospital program, the Council of Teaching Hospitals welcomes the actions contemplated in the resolution which will further this result.

September 1972

VI. COUNCIL OF DEANS 1973 SPRING MEETING

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

August 3, 1972

MEMORANDUM
TO: Administrative Board
FROM: Marjorie P. Wilson, M.D., Director, Department of Institutional Development

SUBJECT: COD 1973 SPRING MEETING

I recently met with Sherm Mellinkoff in Los Angeles to talk about the 1973 Spring program. The attached is the result of our discussion. Sherm suggested the theme which I think is a good one and leaves a lot of room to introduce various "sub-topics."

We would like to have the Administrative Board take full responsibility for the Spring Program this year and not appoint a special program committee. So have at us and tell us very frankly what you think about theme, format, and every detail.

With regard to logistics -- we have the hotel from Wednesday night through check-out time at noon Saturday. We thought in terms of two full days but have checking in only Wednesday night and no program - but start early Thursday with an interesting subject so they will arrive Wednesday night. We will conclude late Friday night, with no program Saturday. They can leave at will then on Saturday and we will not lose our audience.

I feel strongly that we should have at least one workshop session. We got by with the British Parliament approach last year, but there were many people who felt they did not have a chance to speak and requested some small group sessions. I thought they would feel manipulated if split up into small groups; quite the contrary, they felt manipulated locked into the big room being lectured to. We ought to balance the program from this standpoint if we can, so the format I have suggested attempts to do that.

Please look hard at the Session titles or themes and suggest sub-topics for papers or speakers. Also suggest speakers, or better still, volunteer. Incidentally, we need more speakers from outside our own ranks. Also please suggest questions for the workshop on faculty practice plans.

Also, please comment on Sherm's suggestion of legislator's assistants. (The VP's had these people to a meeting and enjoyed it very much.) Please also give some thought to studies we should do in preparation for the meeting.

When I receive your comments I shall revise the attached for discussion at the September 14 Meeting of the Administrative Board. We are planning to have the agenda in your hands by August 28.

I am going to try to be away in August, but if you wish to talk about this I am available. Joe Keyes will be in the office and would be glad to receive your verbal comments if you would prefer to call them in rather than take the time to write.

Best regards.

Copies to: J. Robert Buchanan, M.D.
Ralph J. Cazort, M.D.
Carleton B. Chapman, M.D.
Clifford G. Grulee, M.D.
William D. Mayer, M.D.
William F. Maloney, M.D.
Sherman M. Mellinkoff, M.D.
Emanuel Papper, M.D.
Harold C. Wiggers, Ph.D.

Council of Deans

Hilton Palacio del Rio
San Antonio, Texas

March 7-10, 1973

The Impact of Financing Medical Care on Medical Education

March 7 Wednesday — 7:30 pm — -Registration and Informal Cocktail Hour

SESSION I - Thursday, March 8 - 8:30 am - 1:00 pm

8:30 am - 9:00 am — Conference Format and Expectations
Sherm Mellinkoff

9:00 am - 9:30 am — Private and Group Practice in a Medical School Setting- The Issues

This paper could be one of several things -- some studies are being undertaken on practice plans. These data could be reported with a list of the issues or a summary of the kinds of problems which are encountered. OR a dean could describe from actual experience the adoption of a new plan -- why the conversion was necessary and how it was brought about. OR the subject of this session could be dealt with in another way. In any case data should be made availabe in advance on this subject.

9:30 am - 9:45 am — Break

9:45 am - 11:15 am — Workshops - 4 Groups (20-25 each)

A series of questions would be developed relating to policy and procedural questions which could serve as a rough agenda for the small group discussion and which could provide a framework for the development of a consensus on the answers to some questions. There could be 2 sets of questions and the small groups could be paired or there could be 4 sets of questions or all 4 groups could discuss the same questions. The critical matter will be how good the questions are. I have used this approach of the questions several times now and it is an excellent approach if you want some resolution of questions or problems.

11:30 am - 1:00 pm — Reports from Workshops and General Discussion

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SESSION II - Availability of Patients under Universal Health Insurance

4:00 pm - 6:00 pm

This might be reports from schools with various types of experience -

15 minutes: a. Dependence on community hospital affiliations. (Michigan State or Illinois-Peoria, Rockford)

15 minutes b. Extensive involvement with a disadvantaged urban population. (Mount Sinai)

15 minutes c. Experience of an academic institution with HMO's.

d. Under U.H.I.

Reports should relate to specific problems and solutions, re: the basic question of availability of patients, but also touch on matters of quality control, relations with the practicing community, relationships with the consumers of health care, types of agreements or "contracts."

4:45 - 6:00 General Discussion

6:30 pm - 7:30 pm — Cocktails

7:30 pm - 9:00 pm — Dinner - Speaker

Subject- brief and amusing or at least not on a subject central to the weighty problems of the day.

SESSION III - Friday, March 9 - 9:00 am - 1:00 pm

- Reconciliation of Health Insurance and Medical Education in the Ambulatory Setting

9:00 am - 9:30 am — Health Insurance and Standards of Medical Care

Speaker from 3rd party payers - private or government

9:30 am - 10:30 am — Efficiency and Cost in the Ambulatory Setting - Implications

9:30 - 10:00 - " "....for undergraduate medical Education

10:00 - 10:30 - " "....for graduate education.

10:30 am - 10:45 — Break

10:45 am - 1:00 pm — General Discussion

Note: Sherm suggested we invite the administrative assistants of key legislators to meet with the COD. I would suggest that they not be invited for the workshops on faculty practice plans but for the dinner Thursday night and for Friday. Please comment on this in your replies.

FREE AFTERNOON

Options: 2:00 pm - 4:00 pm

Elective small groups discussions. Several rooms could be set up with the intention that the discussion surround a particular subject with someone on tap along with coffee to facilitate the discussion --

For example some subjects could be:

curriculum and student matters	-- Gus Swanson
HMO's and hosptal affiliations	-- Bob Kalinowski and Dick Knapp
AAMC Management Development Programs	-- MAP Steering Committee members and M. Wilson
Accreditation problems	-- M. Wilson and Jim Schofield
Cost Allocation Studies	-- Joe Murtaugh

OR

COD regional organizations could meet in lieu of separate spring meetings.

DINNER -- Own Choice

8:00 pm - 10:00 pm — Discussion with the President, J. A. D. Cooper

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10:00 pm - Adjournment

University of Cincinnati
Cincinnati, Ohio 45219

COLLEGE OF MEDICINE — EDEN AND BETHESDA AVENUES
OFFICE OF THE DEAN

August 22, 1972

AUG 24 1972

Dr. Marjorie P. Wilson
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Marjorie:

I am sorry to be so slow in responding to your request for comments on the proposed Council of Deans program for the Spring of 1973. Actually, I read it over and thought it was very good. When I read Manny Papper's letter, at first I reacted by thinking that I had been very superficial in my reivew but on continued reflection, felt that one could reasonably expect most of his comments to have been covered in the course of the presentations. Nevertheless, some of his comments were excellent and most pertinent. I do not share all of his reservations with respect to workshops and discussion groups nor his desires concerning the format of the meeting. To me the scheduling is OK including a short, humorous after dinner talk.

See you on the 14th.

Best regards,

C.G. Grulee, Jr., M.D.
Dean

s

UNIVERSITY OF MIAMI
MIAMI, FLORIDA 33152

Mailing Address:
VICE PRESIDENT FOR MEDICAL AFFAIRS
AND DEAN, SCHOOL OF MEDICINE
P. O. BOX 875, BISCAYNE ANNEX

Location:
SEWELL BUILDING
1475 N. W. 12th AVENUE

August 11, 1972

Dr . Marjorie P. Wilson
Director, Department of Education and Development
Association of American Medical Colleges
Suite 200, One Dupont Circle, N.W.
Washington, D. C. 20036

Dear Marjorie:

In accordance with your request I am commenting on the proposed 1973 Spring Program.

I am interested in seeing the first subject in session one developed a little bit differently. I would like some attention paid to the present degree of involvement in remunerative clinical practice by members of the faculties of schools of medicine and why they engage in this kind of practice. How much of it is financial pressure and if so what is the projection for the future? Should a clinical department be the "best" place in its community or environment for the referral of sick patients to treat or should it take the other route of broadening its activities so that medical students and residents can see what they will encounter in practice?

Finally, I would like to see some serious attempt made to assess the degree of such involvement in clinical practice by faculties in both quantitative and qualitative terms. We are really in a stage of transition on this subject and it is worth hearing other peoples views.

I am not one of those people who is enthusiastic about workshops unless they are lead by a very knowledgeable and strong chairman and where the issues and questions to be developed are pretty specific and pretty frank. It is this kind of approach should you hold the workshops that I hope will pertain.

Under session two the availability of patients under Universal Health Insurance is interestingly put together as I look at it.

I think there may be some use in having a summary of all of the pending legislation brought before this group on the question of Universal Health Insurance and what they might mean to the different kinds of institutions that you are going to have presenting.

I have no suggestions about cocktails or dinner except for the fact that I prefer the cocktail hour be short and in general speakers be deleted after dinner but I will be able to happily tolerate the plan that is proposed.

Under session three, I would simply propose that attention be paid to different ways of dealing with ambulatory care not only from a fiscal standpoint but the role of different levels of teaching and the place of mechanization in such an area.

I see no purpose in inviting the administrative assistants of key legislators to meet with the Council of Deans.

My experience with them in Florida and in New York suggests that they are very much involved with the man for whom they work. They are usually bright, tough and on the way up the proverbial ladder of success. It is much better in my view to regard them and work with them on a local, friendly basis. I have chosen for instance to provide them with material both on request from them and on my initiative. I have helped them with written material on a "ghost" basis.

It may very well be that we could take advantage of these kinds of people from the state of California and settle for that.

I have no suggestions about the free afternoon but am inclined to favor without much emphasis on it the regional meetings of COD organization at that time.

I am not one of the violently enthusiastic people about night meetings after both cocktails and dinner. I think the period of productivity at that time is so much lower than during the day that it is almost not worth the effort.

I would therefore prefer to see a discussion period with John Cooper, which I think to be absolutely essential, placed in some other position and that the evening be allowed to be free. There are some people (and I am one of them) who might profit more by going to a concert after two such concentrated days then having one more session when I will have had enough of a certain line of discussion.

I think that you and Sherm are to be congratulated on a very interesting program put together.

Sincerely yours,

E. M. Papper, M.D.
Vice President for Medical Affairs
and Dean, School of Medicine

EMP:jh
P.S. Have a very good holiday!

University of Missouri - Columbia

228 Medical Science Building
Columbia, Mo. 65201

SCHOOL OF MEDICINE
Office of the Dean

Telephone
314 442-5111 Ext. 611

August 23, 1972

AUG 23 1972

Dr. Marjorie P. Wilson, Director
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Marge:

I have just returned from vacation myself and found your memorandum of August 3 concerning the proposed Council of Deans' Retreat on March 7-10, 1973. I'm afraid I cannot be too helpful at this time concerning comments on meeting content for I find that the most effective way for me to deal with this kind of issue is bouncing ideas around in a small group. I think it is appropriate to use the Administrative Board of the COD as the planning committee.

It would be my suggestion, however, if this is to be the case that the next meeting scheduled for September 14 either be extended slightly in the afternoon or initiated earlier in order to provide adequate time for this kind of effort.

In general, the immediate reaction is that the content is pertinent and meaningful. The only other general comment I would make on arrangements is that if you plan to have a free afternoon, I would not put it on the last afternoon of the meeting for I'm afraid you would lose much of the membership. I would strongly favor small group discussions for which people could sign up which were not labeled as "elective," as opposed to spring meetings of the regional organizations.

I do hope we will have sufficient and ample time to discuss this at the next Administrative Board meeting.

Sincerely yours,

Bill

William D. Mayer, M.D.
Dean and Director

WDM:sa

VII. ELECTION OF INSTITUTIONAL MEMBERS

A. The AAMC Bylaw provisions relating to election of institutional members and the procedures for such elections specified by the Executive Council require the following sequence of actions:

1. COD recommendation to the Executive Council;
2. Executive Council recommendation to the Assembly;
3. Assembly election to membership

Since the Executive Council is not scheduled to convene in the interval between the COD Business Meeting, November 3, and the Assembly Meeting on November 4, it will not be possible to follow this sequence precisely if the Assembly is to act upon membership applications this year. Furthermore, with the abolition of the mid-year Assembly meeting, the consequence of the failure of the Assembly to act in November is a full year interval between COD action and final election to membership. To preclude this undesirable result, the following procedural modification is proposed:

1. COD Administrative Board recommendation regarding membership to the Executive Council subject to ratification by the full Council of Deans;
2. Executive Council recommendation to the Assembly contingent upon COD ratification~~, of the Administrative Board recommendation;~~
3. Council of Deans ~~ratification of Administrative Board recommendation;~~ action
4. Assembly action.

RECOMMENDATION: That the COD Administrative Board endorse the above procedure and recommend its adoption by the other affected bodies of the AAMC.

B. The University of South Alabama College of Medicine has been awarded a letter of Reasonable Assurance of Accreditation by the Liaison Committee on Medical Education is thus eligible to election to Provisional Institutional Membership.

RECOMMENDATION: That the COD Administrative Board recommend to the Executive Council that the University of South Alabama College of Medicine be elected to Provisional Institutional Membership in accordance with the above procedure.

C. The following institutions have graduated a class of students and have been accredited by the Liaison Committee on Medical Education; they are thus eligible for full Institutional Membership in the AAMC:

University of California, Davis, School of Medicine
University of California, San Diego, School of Medicine
University of Connecticut School of Medicine
Medical College of Ohio at Toledo

RECOMMENDATION: That the COD Administrative Board recommend to the Executive Council the election of these institutions to full Institutional Membership in accordance with the above procedures.

THE ASSOCIATION OF CANADIAN MEDICAL COLLEGES / L'ASSOCIATION DES FACULTÉS DE MÉDECINE DU CANADA

151 Slater, Ottawa, Ontario, Canada K1P - 5H3 . Area Code 613 . 237-0070 . Cable: CANUF OTTAWA

Refer to file: Mentionnez le dossier:

September 1, 1972

Dr. John Cooper
President
Association of American Medical Colleges
One Dupont Circle N.W.
Washington, D.C.,
U. S. A. 20036

Dear John,

The Faculty of Medicine, McMaster University, at the request of the Dean, Dr. J.F. Mustard, will be welcomed as an Institutional Member of ACMC at our annual meeting on October 2, 1972.

As you know, McMaster graduated its first class a few months ago and has been fully approved by LCME following a survey visit in March of this year.

Dr. Mustard, who succeeded Dr. Evans as Dean on July 1, 1972, has also assured me that McMaster would be honored to become an Affilate Institutional Member of AAMC. I hope appropriate action can be taken at your annual meeting.

I hope you will be able to attend our meetings in Montreal, October 2-3. If this is not possible, I will look forward to seeing you in Miami.

Sincerely,

John

John B. Firstbrook, M.D., Ph.D.
Executive Director

JBF/kf
c.c. Dr. J.F. Mustard
Dr. J.R. Evans

UNIVERSITY of SOUTH ALABAMA

COLLEGE OF MEDICINE
OFFICE OF THE DEAN

MOBILE, ALABAMA 36688
TEL. 205/460-7188

September 7, 1972

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

Dear John:

Having received reasonable assurance of accreditation from the Liaison Committee on Medical Education and being in the process of enrolling a class to begin in January, I believe that the institution is now qualified for provisional membership in the Association of American Medical Colleges. The purpose of this letter is to formally request such membership. I would appreciate if it you would send to me the application forms or other information on steps which we should take to achieve this status.

May I express to you deep appreciation for the help rendered by the association in our planning. I look forward to additional assistance from you and hope that this institution can work with the others in achieving the goals of improved health education.

Sincerely yours,

Robert M. Bucher, M.D.
Dean

RMB/fc

INFORMATION ITEM

I. REPORT OF THE FOLLOW-UP TO COD RESOLUTIONS

On May 18, 1972 the Chairman of the COD reported to the Executive Council the action of the Council of Deans at its Spring Meeting in Phoenix in adopting two resolutions relating to the assessment of the quality of medical education and of health services. Subsequently, the Association's Executive Staff reviewed the resolutions with the President with the following disposition:

1. It was the expressed view of the Executive Staff that the first resolution relating to the quality of medical education expressed the general mission of the AAMC and that a number of ongoing programs covered the range of considerations contained in the resolution. Dr. August Swanson, Director of the AAMC Department of Academic Affairs prepared the attached statement outlining the relevant programs.

2. The Executive Staff referred the second resolution to the Association's Health Services Advisory Committee for appropriate action. This Committee considered the resolution at its May 31, 1972 meeting. It concluded that it had begun to develop the operational program to implement the second half of the resolution--"assessing the appropriate role of the academic medical centers in the delivery of health care, especially in relation to any future national health insurance program." It agreed that a subcommittee should be appointed to review with other leaders in the health field existing studies and assessments on the quality of care. The subcommittee has been appointed and consists of the following members:

Robert J. Weiss, M.D.
Associate Dean - Health Care Programs
Harvard Medical School

Richard L. Meiling, M.D.
Vice President for Medical Affairs
and Director, University Hospitals
Ohio State University

Christopher C. Fordham III, M.D.
Dean
University of North Carolina School of Medicine

This subcommittee has been asked to report back to the Health Services Advisory Committee at its next meeting. In addition, it has been asked to be prepared to report its findings to the COD at its business meeting on November 3.

John Westerman

Chairman of Med. Sch of Ind.

Comments on the Council of Dean's resolution passed at the Phoenix meeting.

> The Council of Deans recommends that the AAMC undertake a major study of undergraduate and graduate medical education programs, a study which has at its focus the definition of the quality of their product in quantifiable terms. This should include: (A) The development of standards and priorities by which the quality of educational programs may be assessed; and (B) The identification of the relationship between the performance of the physician and his educational experience.

Assessing the outcomes of medical education is of continuous concern to the AAMC and its constituent members. In the past, the medical schools and the Association chiefly limited their interests and responsibilities to selecting students and providing the education necessary for them to attain the M.D. degree. Little concern or responsibility was directed toward students' graduate education or their ultimate performance in medical practice. The spirit of this resolution makes obsolete the old, narrowly-defined mission of the academic medical community and the AAMC and acknowledges that medical educators must become engaged with every level of professional activity in medicine.

In determining how the Association should facilitate the effective expansion of responsibility for its constituency, the elements of the resolution must be analyzed and the current and planned activities of the Association must be inventoried and evaluated regarding their contributions to the goals of the resolution.

There are two major elements in the resolution: 1) Developing standards and priorities for assessing the quality of both undergraduate and graduate programs; 2) Identifying the relationship between the educational process and the ultimate performance of physicians in practice. Interrelating these elements implies that standards of educational quality should be dependent upon the assessment of ultimate performance in practice.

The quality of an educational program is determined by:

1. The quality of the students;
2. The quality of the faculty;
3. The nature of the curriculum;
4. The nature of the instructional experiences provided to students by faculty within the constraints of the curriculum;
5. The nature of the evaluation of the effectiveness of institutional instructional programs;
6. The nature of the evaluation of student achievement.

Assessing these determinants of the educational programs of medical schools has largely been limited to academic standards set by institutions for institutions and the yard stick of ultimate professional performance has never been applied. Presently there are many programs and projects under way at the Association which will significantly modify these old standards and improve the procedures for establishing new standards and priorities.

A. The revision of the Medical College Admissions Test.

A three-year program for revision of the MCAT is under way. This is directed toward improving the MCAT as an instrument for detecting those qualities in applicants which are deemed desirable which are not now measured. Biographical and other noncognitive indicators will be explored and the feasibility of including data which are predictors of problem-solving ability and personal patient care proclivities versus interests in technical skills will be studied. In carrying out this task, those responsible will have to pay particular attention to the performance outcomes desired by the public, the academic faculties and the practicing profession.

B. The Longitudinal Study.

This study involves 2,200 M.D.s who graduated from 28 medical schools in 1960. During their four undergraduate years, intensive studies were made of this cohort. These data are being transferred to computer tapes and will be available for studying outcomes. In conjunction with the AMA--which has the follow-up data needed to locate and make first descriptions of these physicians--and the NCHSRD--which has interests in relating educational experience with ultimate performance--several studies are planned. A workshop was held June 6, 7 and 8 bringing together the principal investigators working on performance measures for physicians. Although a firm protocol was not adopted, it is believed that a

study plan can be evolved which will allow investigations into questions relating to educational experience and ultimate performance. It is expected that these studies will be directed toward both selection factors and the educational process and thus will be relevant to the MCAT revision program and the Curriculum Survey described below.

C. Curriculum Survey.

In April 1972, all U.S. and Canadian medical schools were asked to provide a detailed description of their undergraduate curricula. The purpose is to provide current information on what is happening in undergraduate medical education and to distribute a book which shows precisely the courses taught, the hours devoted to each course, the amount of free time students are provided, elective programs, pathways for early tracking, special clinical and scientific experiences and other data. It is expected that these data will enable the academic medical community to assess what is perceived as the educational mission of the undergraduate program in each medical school. While formal queries regarding standards and priorities were not made, these should be inferrable from the data.

D. New educational technologies.

An outcome of the AAMC report on New Roles for the Lister Hill Center in Promoting New Educational Technology was the generation of a second report, now in progress, on

the responsibilities of the institutions and faculties for making full use of new technologies. A significant recommendation of the committee preparing this report is that the AAMC should establish a resource to assist the schools in developing and reviewing multimedia instructional programs. Inherent in this thrust is the need for faculties to articulate standards and priorities, for unless the objectives of creating or purchasing multimedia instructional packages are determined in advance, very costly mistakes will be made. Negotiations are under way with the NLM to establish such a resource through cooperative interaction between the NLM and the AAMC.

E. Continuing Medical Education Study Committee

This committee will have its report ready by the fall. The thrust of committee discussions indicate that the faculties should work with practicing physicians in establishing criteria of performance, measure performance against these criteria and then direct educational efforts toward narrowing the gap between accepted criteria and actual performance. Thus, this committee is also emphasizing the need for setting standards and priorities and relating them to the objectives of the educational process.

F. The National Board of Medical Examiners' Committee on Goals and Priorities

The committee is preparing a report regarding the future needs for a national evaluation system for both undergraduate

and graduate medical students. Although it is an NBME committee, it is chaired by Bill Mayer and the makeup of the committee (shown below) assures strong input from the Association and its constituents. The committee has discussed extensively the need to tailor future exams to the expected performance of students in practice.

Members of NBME Committee on Goals and Priorities:

Dr. William D. Mayer, Chairman
Missouri

Dr. Stephen Abrahamson
USC

Dr. John R. Evans
McMaster

Dr. Robert L. Hill
Duke

Miss Margaret Mahoney
Robert Wood Johnson Found.

Dr. C. Barber Mueller
McMaster

Dr. Thomas E. Piemme
George Washington

Dr. Melvin Sabshin
Illinois

Dr. August G. Swanson
AAMC

Dr. D. Dax Taylor
Southern Illinois

Dr. James V. Warren
Ohio State

The activities listed in A through F directly relate to the spirit of the Council of Deans' resolution in the area of student quality, curricular design, instructional design and the assessment of student achievement. The net effect of these activities will be to focus attention on setting standards and priorities which relate to performance outcomes. Of the 6 quality determinants on page 2, only two are not directly covered by the activities discussed in A through F. These are determining faculty quality and investigating the nature of institutional procedures for evaluating educational program

effectiveness. Both of these will indirectly be affected as the various activities evolve.

The activities listed above are, or course, in addition to the Association's heavy involvement in the accreditation of medical education programs. The AAMC is represented on the Liaison Committee on Medical Education; six of the fourteen LCME members are appointed by the AAMC Executive Council. The Association staff provides the Secretariat in alternating years and is continually involved in the process of revising LCME standards, policies and procedures. The document "Structure and Function of a Medical School," which serves as the statement of basic LCME policy and the standards on which accreditation decisions are based, has recently been revised and will be presented for Assembly approval at its next meeting. The document "Programs in the Basic Medical Sciences" setting forth LCME policy with respect to medical education programs not culminating in the M.D. degree has also been revised and is in the early stages of the approval process. Other relevant LCME activities include the exploration of means by which the accreditation process may serve as a more useful stimulus to productive self-examination by the institutions.

In the near future the activities of the Graduate Medical Education Committee, charged with the implementation of the corporate responsibility concept, and the input of the AAMC to the Liaison Committee on Graduate Medical Education and the Coordinating Council for Medical Education will have major effects upon the development of standards and priorities which relate to the linkage of the graduate educational process to ultimate physician performance.

Because so many of the activities of the Association are directed toward the spirit of the resolution, a separate study seems inappro-

priate. Rather, this resolution might be considered a mandate requiring that educational standards and priorities must be directed toward improving the performance of practicing physicians and that the AAMC and its constituents must assume leadership on all related fronts including graduate medical education and the evolution of this Nation's health service system. Such a mandate would provide strong impetus to both at once broaden the horizons and focus the attention of the Association and its constituent members.

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

6-14-72

INFORMATION ITEM- II

COD ACTIVITIES AT AAMC ANNUAL MEETING

A. COD calendar of meetings in conjunction with the AAMC Annual Meeting is set as follows:

Thursday, November 2, 1972
4:00 pm - 6:00 pm Council of Deans/Veterans Administration Joint Session

Friday, November 3, 1972
(Noon to 1:30 pm Administrative Board Luncheon Meeting)
2:00 pm - 5:00 pm COD Business Meeting

Sunday, November 5, 1972
9:00 am - 12:30 pm COD/CAS Joint Meeting

B. Joint Session of COD with Veterans Administration - (Program, Attachment I of May 18 Minutes)

C. COD Business Meeting Agenda Items

1. Organization of Faculty Representatives
2. Structure and Function of Medical School
3. Spring COD Program
4. Report of Ad Hoc Committee to Consider Medical School Admissions Problems
5. Report of Health Services Advisory Committee re: COD Resolution
6. Report on Management Advancement Program
7. Report of Nominating Committee and Election of Officers

D. COD/CAS Joint Meeting - (Program, Attachment II of May 18 Minutes)

INFORMATION ITEM - III

SCHEDULE OF REGIONAL MEETINGS

September 28 - 29, 1972 — WESTERN REGION

Place: San Francisco Hilton Airport Hotel
Agenda:

October 2 - 3, 1972 — MID-WEST GREAT PLAINS REGION

Place: Regency Hyatt House Hotel, Chicago
Agenda: "Quality Control of Medical School Faculty"

October 9, 1972 — SOUTHERN REGION

Place: Air Host Inn, Atlanta
Agenda: Faculty Representation and new chairman for Southern Region

NORTHEAST REGION

INFORMATION ITEM - IV
HEALTH SERVICES ADVISORY COMMITTEE
A. MINUTES OF MAY 31 MEETING

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES

Health Services Advisory Committee
AAMC Conference Room
May 31, 1972

Present

Robert M. Heyssel, M.D., Chairman
Luther Christman
Christopher C. Fordham III, M.D.
M. Alfred Haynes, M.D.
Richard L. Meiling, M.D.
Stuart M. Sessoms, M.D.
Robert J. Weiss, M.D.
John H. Westerman

AAMC Staff

John A. D. Cooper, M.D.
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Marjorie Wilson, M.D.
Stephen J. Ackerman
Grace Beirne
Alexa Burt

Absent

Robert G. Lindee
Ernest Saward, M.D.
Anne R. Somers

The second meeting of the AAMC Health Services Advisory Committee was held on May 31, 1972 in the AAMC Conference Room in Washington.

1. Introductory Remarks

Dr. John A. D. Cooper extended a welcome to the Committee members and expressed appreciation for the benefit of their advice and counsel in the development of the project to study Health Maintenance Organization program development in the university medical center environment. Dr. Cooper told the members that he looked forward to their further assistance to the Association in its plans for a continuing review of all important aspects of health service progress in the academic health center.

Dr. Cooper also gave the Committee information on the AAMC testimony on HMO legislation before the Health Subcommittees of the Senate Committee on Labor and Public Welfare and the House Committee on Interstate and Foreign Commerce. He expressed warm praise and appreciation of Dr. Heyssel's performance in this regard.

2. Task Force on Cost of Graduate Medical Education and Faculty Practice Plans

The establishment of the new ad hoc group was discussed with the Health Services Advisory Committee. Its purpose as set forth in the "charge" to the Task Force is: "Graduate medical education and the delivery of health services occur simultaneously and include a complex set of cost relationships. The Committee is charged with responsibility for identifying and defining those factors or components which comprise the sum total of the program costs of providing graduate medical education. One of the sources of financing graduate medical education costs,

as well as other costs, are faculty practice plans. The Committee is further charged to assemble the data and information regarding faculty practice plans, and their relationship to financing the costs of graduate medical education."

The work of this group will be related to the Cost Allocation Study undertaken by the AAMC under a contract with HEW several years ago. That project is currently engaged in a review of a sample of twelve medical schools, public and private, from various parts of the country for the purpose of arriving at an approximation of the range of costs of medical education. A copy of the breakdown of categories contemplated for this purpose was distributed and discussed. The schools involved in this aspect of the study are paired on the basis of like characteristics and include:

Albany-Medical College of Wisconsin

Case Western Reserve-Duke

Georgetown-St. Louis

Kansas-SUNY Upstate

Ohio State-Iowa

Utah-Vermont

A meeting of the Task Force was scheduled for June 12 in Washington. Its members are:

William J. Anlyan, M.D., CHAIRMAN
Vice President for Health Affairs
Duke University School of Medicine

Christopher C. Fordham III, M.D., Dean
University of North Carolina School of Medicine

William J. Grove, M.D.
Executive Dean
University of Illinois College of Medicine

Robert M. Heyssel, M.D., Director
Office of Health Care Programs
The Johns Hopkins Medical Institutions

Arnold S. Relman, M.D.
Chairman, Department of Medicine
The University of Pennsylvania School of Medicine

Charles B. Womer
Executive Director
Yale-New Haven Hospital

3. Committee on RMP-CHP

Dr. Cooper also announced the establishment of the Committee on RMP-CHP under the chairmanship of Dr. Stuart M. Sessoms. The committee, whose purpose is to give consideration to the future directions of the Regional Medical and Comprehensive Health Planning Programs in the light of the forthcoming expiration of their legislative authorization, is comprised of the following members:

Stuart M. Sessoms, M.D., CHAIRMAN
Director
Duke University Hospital

William S. Jordan, Jr., M.D.
Dean
University of Kentucky College of Medicine

Alexander M. Schmidt, M.D., Dean
The Abraham Lincoln School of Medicine
The University of Illinois

William H. Stewart, M.D.
Chancellor of the Medical Center
Louisiana State University

James V. Warren, M.D.
Chairman, Department of Medicine
The Ohio State University
College of Medicine

Andy Hunt

In expanding on the committee functions, Dr. Cooper explained that the Association will have an opportunity to make some recommendations for renewal of the RMP and CHP legislation when it is introduced in the Ninety-third Congress. Senator Kennedy had included extension of these programs in his HMO Bill, Title V, but has agreed to delete these provisions so that the legislation may be considered separately next year. It was further indicated that Dr. William Willard of Kentucky, who had previously headed a committee appointed by Dr. Vernon Wilson to review the RMP-CHP programs for HSMHA, had accepted an invitation to meet with the newly-formed committee. The report of the Willard Committee has never been released by HSMHA but was widely reported to have recommended a combination of the two programs with funding through a strengthened CHP. The committee meeting is scheduled for June 18 in Washington.

4. Academic Health Centers and Ambulatory Care

This subject was identified as the next prime target for the attention of the Health Services Advisory Committee. The following outline was distributed to provide a framework for discussion on the subject:

Academic Health Centers--Ambulatory Teaching Programs

I. Amount of Services Delivered as a function of:
   A. Societal demand
   B. Educational and research needs
   C. Financial consideration

II. Method of Provision of Services
   A. OPD and ER
   B. Private faculty practice groups

C. HMO's

D. Neighborhood Health Centers

III. Reimbursement

A. Federal and State

B. Other third party--Blues and commercial

C. Higher cost of care in a teaching setting

IV. Relationship to:

A. AHEC

B. RMP & CHP and regionalization (regional and national)

C. Community involvement

Salient points of the ensuing discussion included:

1. A look should be taken at the whole area of ambulatory care and the outpatient department and emergency room were suggested as appropriate places to begin. It represents a common and growing problem in all academic medical centers--both from quantitative and qualitative standpoints. However, it is in danger of being over-looked and overshadowed in view of the current concentration of attention on HMOs.
2. In a general brainstorming session, a number of ideas were thrown out for consideration in developing the program:
   a. A strong educational effort on the issue of primary care is needed to be aimed at the AAMC constituency, the Federal government and the consumer.
   b. Needs for information and data were seen such as: studies of the ambulatory care process in the academic medical center (reports in JME on studies in Kansas and Hartford Hospital were cited); evaluation of ambulatory care on a cost-effective basis;

collaborative studies with the insurance industry and Blue Cross; and dissemination of relevant data from the Medicaid program.

c. Among ideas for action mentioned were to devote an entire meeting of the committee to primary care; to foster an AAMC meeting on the quality of education in relation to health services; a concern with the issue of adjustment of the faculty reward system--perhaps as a topic at the Annual Meeting; and inclusion of the quality of primary care as a factor for consideration in accreditation visits (this presumes development of a set of criteria for the purpose).

3. The staff of the AAMC Division of Health Services is to consider program possibilities in the light of suggestions and report back to the Advisory Committee.

5. Prison Medical Care and National Health Service Corps

Dr. Kalinowski led a discussion on the issue of the academic medical center's relationship to the problem of health care in prisons. He reported on the meeting of May 15 of a selected group of medical schools with the most active programs in this area which was sponsored jointly by the Commonwealth Fund and the AAMC.

He also described the possibilities of a project under which the AAMC would assist the National Health Service Corps by coordinating a program whereby academic medical center personnel could provide preceptorial, educational and other support to NHSC assignees in the field.

6. HMO Project

Dr. Kalinowski and Mr. Ackerman reported on the development of a Final Report to HSMHA on the project to study HMO program development in the university medical center. A copy of the final draft was included in the agenda booklet and comments or suggestions of the Advisory Committee were solicited. Negotiations with HSMHA for Phase II of the project under which planning and development of HMO prototypes in line with the recommendations of the above mentioned report were described. The outlook is that HSMHA wishes to limit the number of prototype HMO developments under the project to five. The process of selection of prototypes and participating institutions is described in Section IV of the report (page 14 of the Final Draft).

7. Resolution of the Council of Deans

The Committee then considered a resolution passed by the Council of Deans at its meeting in Phoenix on April 23, 1972, and referred to the Health Services Advisory Committee. The text of the resolution follows:

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

The Committee felt that it was beginning to develop the operational program to implement the second half of the resolution and agreed that a subcommittee should be appointed to review with other leaders in the health field existing studies and assessments on the quality of care and to report back to the Health Services Advisory Committee at its next meeting in Miami on November 3, 1972.

FINAL REPORT

Project Title: HMO Program Development in the University Medical Center (#03-P-000, 419-01-0)

Grantee: Association of American Medical Colleges

I. BACKGROUND AND APPROACH

In summary, the specific objective was to foster the development of health maintenance organizations in the university medical center environment through experiences derived from a planned series of HMO projects. Secondary aims included improving the educational and research functions of medical schools in regard to the delivery of health care and accordingly to advance the effective integration of medical education and medical care. Extramural aims included fostering improvement in patterns of interrelationship of the university medical centers with the medical care delivery and health manpower education systems around them. From an overall standpoint, the goal in undertaking the project was to more effectively bring to bear the resources of the university medical center in the improved delivery of medical care through the HMO approach.

Underlying the AAMC motivation in undertaking this project was a belief that a unique and special importance attaches to the involvement of the academic medical center in the development of new and innovative experimentations in health care delivery systems. It is the prime producer of manpower necessary for the delivery system. It has unique conceptual, quantitative and analytical capabilities and it has access to the full spectrum of disciplines in the health, social and behavioral sciences that are essential to dealing with the complexities of health care system development.

However, along with the unique potential, there are unique problems attendant to the academic health center involvement in the development of HMOs and other approaches to the delivery of health care. Our approach therefore was to focus on those critical issues that represented the real barriers to major involvement of the academic medical center in the development of HMOs for the improved delivery of primary, comprehensive continuing health services. Our thesis was that if the most important of the critical issues common to such institutional involvement could be identified and analyzed, a basis could be provided for the development of approaches to these solutions in the form of prototype experiments.

Another very important aspect of the AAMC HMO project design was in a centripetal approach in which primary emphasis was placed on contributions from those with field experience.

The project was conducted with a very small central staff and sought to achieve maximal involvement of those from the university medical center milieu having actual relevant experience and competence in HMO and similar types of health care delivery programs. This was done in a number of ways:

1. The newly established Health Services Advisory Committee of the AAMC was used as a major resource for review and advice. This group is chaired by Dr. Robert M. Heyssel, Director of the Office of Health Care Programs, who developed the Johns Hopkins sponsored HMO programs in East Baltimore and at the new town of Columbia, Maryland. Members of the committee include: Dean Luther Christman, College of Nursing and Allied Health, Rush Medical College; Dr. Christopher C. Fordham, University of North Carolina School of Medicine; Dr. Alfred Haynes, Charles R. Drew Postgraduate Medical School; Robert Lindee, Vice President of the Kaiser Family Foundation; Dr. Richard Meiling, Ohio State University School of Medicine; Dr. Ernest Saward, University of Rochester School of Medicine and Dentistry; Dr. Stuart Sessoms, Duke University Medical Center; Mrs. Anne Somers, Rutgers Medical School; Dr. Robert Weiss, Harvard Medical School; and John Westerman, University of Minnesota Hospitals.

2. Key people at the schools having active HMO involvement were used as a special consultant group to gain the benefit of the perspectives and insights of those struggling with the actual problems in real life.

3. The workshop mechanism was selected as the modality of choice in defining the critical issues and determining approaches to solution in order to secure involvement of all the "workers" active and interested in the field.

4. A major aspect of the workshop decision was to highlight the experience of those institutions who had actual experience in HMO development and operations. Therefore, presentations by key people closely involved with such developments at Yale, Harvard, Johns Hopkins and Washington University (St. Louis) were focused on the problems and difficulties encountered rather than "success-story" statements of a promotional type.

In summary, in a field such as HMO program development in the academic medical center where there are no experts but only experts in particular aspects, our strategy was to look at those who were out where the action was--actively engaged in the struggle to bring university health service programs into being and make them go.

II. THE CRITICAL ISSUES OF UNIVERSITY MEDICAL CENTER INVOLVEMENT IN HMO PROGRAMS

In order to provide the fundamental frame of reference for the project, we undertook to develop a basic list of those significant factors which attach to university medical center endeavors with such projects. A tentative array and outline of these so-called "critical issues" was developed by a staff consultant on a basis of a literature review of available reports on HMO-type programs--both academically and non-academically related (a copy is attached). In line with our strategy of involvement, we asked the key people at thirty of the academic medical centers that were the most advanced in feasibility study,

planning and development of HMOs to give it critical scrutiny for validity and completeness in the light of their experience.

The tentative list of critical issues provided a sound baseline and received a general validation from the consultant group with regard to the essential adequacy and accuracy of its content. However, some valuable suggestions were made for the inclusion of additional factors and more detailed breakdown of some items. The most frequent suggestions, for example, proposed more focus on mental health, and consumer education aspects and the problems of change stresses in institutions and professions. A general comment common to a number of the reviewing consultants was the fundamental interrelationship of the principal issues. For example, it was felt to be difficult--if not impossible--to deal with the issue of "organizational structure" of the HMO apart from that of its "governance."

The list of critical issues--as modified by the suggestions of the peer consultant group and--after review by the AAMC's Health Services Advisory Committee then provided a focus for the series of HMO Workshops designed for the participation of academic medical center staffs throughout the country. The general groupings were:

1. The definition and articulation of objectives of the institution in HMO project development
2. The organizational structuring of the HMO
3. Governance
4. Intramural relationships
5. Extramural relationships
6. Professional medical component
7. Management component
8. Fiscal structure
9. Legal aspects
10. Facilities

A copy of the full outline is attached.

III. AREA WORKSHOPS

The "area workshop" was chosen as the major "modus operandi" for the project. As previously noted, its use as the mechanism of choice was based on the theory that the best source of knowledge and insight about the principal problems and barriers of university medical center endeavors in HMO type programs--as well as for the delineation of realistic approaches to their solution--are those in active engagement with these issues in the academic medical center milieu. At

the same time, we wanted to expose and stimulate the interest of those institutions that had not given serious attention to the question of involvement with HMO type programs. Therefore, a series of eight workshops was structured geographically so as to delivery a thoroughly balanced distribution of participants with active HMO involvement in each. The idea was that this more experienced group would form the nucleus of the workshop function but that all schools in the area would be invited. Another sturctural consideration was size. We were very anxious to preserve the informality and free-wheeling exchange of the workshop form as opposed to the ridigities of the large conference type affair, so we aimed at forty as an optimal size and sought to keep any from being too small or too big in numbers by prescribing the constituency for each workshop. More than 500 individuals participated in the workshops, all--except speakers and consultants--at their own expense. This included some 364 people from 109 academic medical centers--or almost every one in the country. The other attendees included university administrators and trustees, representatives of medical associations, hospital administrators, insurance company executives, students, consumers, and other interested individuals.

Key staff of the Health Maintenace Organization Service of HSMHA, the Bureau of Health Manpower of NIH, and regional office representatives participated in several of the workshops. A feature of the Southeastern Area Workshop at the University of North Carolina was a presentation by Dr. Vernon Wilson, Administrator of HSMHA.[1]

Northeast Area (January 13-14, 1972)

Coordinator: John D. Thompson, Ph.D.
Associate Dean
Yale University School of Medicine

Schools Represented: University of Connecticut, Yale University, Boston University, Harvard University, Tufts University, Dartmouth Medical School, Albany Medical College, Mount Sinai School of Medicine, University of Rochester, State University of New York at Syracuse, University of North Carolina, Brown University, and University of Vermont. (Total: 13)

Attendance (Total)	58
University Medical Center Staff	54
Others	4

Middle Atlantic Area (January 29-30, 1972)

Coordinator: Robert R. Huntley, M.D., Professor and Chairman
Department of Community Medicine and International Health
Georgetown University School of Medicine

Schools Represented: George Washington University, Georgetown University, Howard University, Loyola University Medical Center, University of Kentucky, University of Louisville, Johns Hopkins University, University of Maryland, Meharry Medical College, University of Tennessee, Vanderbilt University and University of West Virginia. (Total: 12)

Attendance (Total)	48
University Medical Center Staff	39
Others	9

Middle U.S. Area (February 8-9, 1972)

Coordinator: Gerald T. Perkoff, M.D.
Director, Division of Health CAre Research
Washington University School of Medicine

Schools Represented: Chicago Medical School, University of Illinois (Abraham Lincoln), Loyola University, Rush Medical School, Southern Illinois University, Indiana University, University of Iowa, University of Kansas, University of Michigan, Michigan State University, Wayne State University, Mayo Graduate School of Medicine, University of Minnesota at Minneapolis, University of Missouri at Kansas City, St. Louis University, Washington University, Creighton University, University of Nebraska, Case Western Reserve University, Medical College of Ohio at Toledo, Ohio State University and University of Wisconsin. (Total: 22)

Attendance (Total)	70
University Medical Center Staff	51
Others	19

Philadelphia Area (February 14, 1972)

Coordinator: Aaron D. Freedman, M.D.
Associate Dean
University of Pennsylvania School of Medicine

Schools Represented: Hahnemann Medical College, Jefferson Medical College, Medical College of Pennsylvania, Pennsylvania State University, University of Pittsburgh, University of Pennsylvania, Temple University and Philadelphia College of Osteopathic Medicine. (Total: 8)

Attendance (Total)	49
University Medical Center Staff	37
Others	12

Southeastern Area (February 15-16, 1972)

Coordinator: Cecil G. Sheps, M.D.
Vice Chancellor for Health Sciences
University of North Carolina School of Medicine

Schools Represented: University of Alabama, University of South Alabama, University of Florida, University of Miami, Emory University, Medical College of Georgia, University of Mississippi, Bowman Gray School of Medicine, Duke University, University of North Carolina, Medical University of South Carolina, University of Virginia, and Virginia Commonwealth University. (Total: 13)

Attendance (Total)	38
University Medical Center Staff	32
Others	6

Western Area (February 28-29, 1972)

Coordinator: John E. Kralewski, Ph.D.
Director, Division of Health Administration
University of Colorado Medical Center

Schools Represented: University of Arizona, University of Arkansas, University of Colorado, Louisiana State University at New Orleans, Tulane University, University of New Mexico, University of Oklahoma, Baylor University, University of Texas System, and the University of Utah. (Total: 12)

Attendance (Total)	52
University Medical Center Staff	32
Others	20

Pacific Coast Area (March 1, 1972)

Coordinator: Julius R. Krevans, M.D.
Dean of the School of Medicine
University of California at San Francisco

Schools Represented: Charles R. Drew Postgraduate Medical School, University of California at Davis, Irvine, Los Angeles, San Diego, and San Francisco, Loma Linda University, University of Southern California, Stanford University, University of Nevada, University of Oregon, University of Utah, and University of Washington. (Total: 13)

Attendance (Total)	76
University Medical Center Staff	58
Others	18

New York Area (March 9-10, 1972)

Coordinators: John E. Deitrick, M.D., Director
Associated Medical Schools of Greater New York

Sherman Kupfer, M.D.
Associate Dean
Mount Sinai School of Medicine

Schools Represented: Indiana University, University of Missouri, College of Medicine and Dentistry of New Jersey at Newark, Rutgers Medical School, Albany Medical College, Columbia University, Cornell University, Albert Einstein College of Medicine, Mount Sinai School of Medicine, New York Medical College, New York University, State University of New York Downstate Medical Center, SUNY at Stony Brook, SUNY Upstate at Syracuse, University of Rochester, and University of Puerto Rico. (Total: 16)

Attendance (Total)	115
University Medical Center Staff	61
Others	54

In determining the host sites, the workshops were placed at university medical centers where unique approaches to HMO development were underway. This facilitated a diversity of approaches. The Washington, D.C. workshop had a bonus in this regard since both Georgetown and George Washington Universities had support for the development of two quite different types of HMO. This brought about a sharing of the host responsibility. Dr. Thomas Piemme of George Washington collaborated closely with Dr. Huntley, the coordinator, and the workshop was held on the George Washington campus.

To assure a reasonable degree of uniformity amongst the diversity, however, a general protocol was developed for all the workshops. It formed the basis of a contract with the respective coordinators. The key elements centered in the contract included the following:

Purpose: To permit sharing of experiences in HMO planning and operation to provide expert consultation for dealing with the critical problems of HMO development; and to make recommendations concerning the priority of issues for which research and evaluation should be undertaken in experimental prototype HMO projects.

Program: Coordinators were responsible for development of the programs for the workshop in colaboration with a steering committee composed of some of the individuals having primary responsibility for HMO-type projects at their home institutions. This group was free to plan and structure the workshop as they saw fit, except for the following mandated requirements:

1. The agenda had to include consideration of at least three of the major topics within the scope of the prime critical issues identified by the project staff and the AAMC Health Services Advisory Committee;

2. The program had to include presentation of three to six papers of publishable quality, each dealing with one or more of the critical issues.

Report: The submission of a report on the proceedings of the workshops was asked for within thirty days of its completion. A specific format was prescribed, the prime essence of the report being a) the principal papers read at the sessions, and b) identification of the recommendations of the workshop covering the nature and priority of the issues for which research and evaluation should be undertaken in prototype HMO experimental projects.

IV. WORKSHOP OUTPUT AND GENERAL CONCLUSIONS

Original basic assumptions about the problems and potential of the academic medical center were well borne out by the workshop results. A general message which came through clearly in all of the meetings without exception was that there are some very real barriers to effective large-scale involvement of academic medical centers in HMO program development.

It was very clearly recognized that the successful planning and operation of a prepaid group practice is a complex and difficult process in itself. Moreover, the fact that a university is involved not only tends to intensify some of these basic difficulties but brings into play a whole set of problems that are unique to the academic medical center itself. These include its basic nature as an academic institution; the complex and deep-seated set of relationships within the university community; the exquisitely sensitive and intricate set of relationships to the community outside the walls including professional, governmental and societal. The problem is further complicated by the fact that there is a great degree of difference among these variables and their combinations from institution to institution. In this regard there was a general sense of opinion that not all university medical centers could or should be involved in an HMO development. On the other hand, there was a diversity of opinion as to the nature and extent of the involvement wherever a course was deemed feasible and appropriate. It was suggested that this was a matter for each university to study and determine in the light of its own situation.

On the other hand, in spite of the sanguine reality and blunt frankness in addressing the problems implied above, the workshop constituency nevertheless produced clear evidence of a widespread and strong tide of interest among academic institutions in the HMO phenomena. Most importantly through all of the caveats and concerns expressed there emerged a powerful and pervasive pan-institutional conviction that if HMOs are destined to be a major method for improved delivery of health care in the country, the academic medical center has a unique and exclusive potential and responsibility with regard to them and must, therefore, inevitably be involved with them.

In addressing themselves to the critical issues of university HMO involvement, the workshops sought to shed light on the barriers and possible solutions. It is the aggregate of the papers presented, group discussions, and recommendations of the workshops that provides the sense of direction and priority of concern about the critical issues which are recommended as targets for prototype project focus.

V. PROTOTYPE HMO'S FOR UNIVERSITY DEVELOPMENT

The dictionary gives four meanings for the term prototype:

1. The original or model on which something is based or formed;

2. Something that serves as an example of its kind;

3. Something analogous to another thing of a later period;

4. An archetype; a primitive form regarded as the basis of a group.

It is interesting to note that all four of the definitions have a meaning of special significance when applied to the HMO prototypes to which this project is addressed. It is contemplated that they could be models to serve as examples for the entire field of academic medical centers and at the same time that they represent experimental ventures from which a sequence of new growth, mutations and variants would evolve. The benefits of being a prototype HMO project under this program would include: prestige and satisfaction in terms of the opportunity to break new ground and add new knowledge; and the benefit of special technical assistance. The burdens would include submission to a certain amount of group discipline including standardization of definitions, systems and reporting and the assumption of a responsibility for documentation of the prototype experience.

The role of the prototype project was succinctly put in the original grant application submitted to HSMHA as follows:

> "The proposed project, therefore, undertakes to carry out a systematic process to provide definition and criteria concerning the issues that are critical to university medical center involvement in HMO program development. This will permit the delineation of a series of prototype HMO projects which focus on the major distinct sets of problems which must be dealt with in developing the potential of the HMO concept in the entire field."

The purpose of benefiting the entire field rather than solely the grantee institutions was clearly set forth in the original letter of intent sent by Dr. John A.D. Cooper, President of the AAMC,to Dr. Vernon Wilson, Administrator, Health Services and Mental Health Administration, before undertaking this project in the following terms:

> "Selection must be accomplished in such a manner as to make the entire body of university medical centers feel a relationship to and benefit from the prototype experiments."

Procedure for Qualification of Prototype Projects

After the final version of this report has been accepted by HSMHA, it is proposed that it be transmitted to all academic medical centers through normal AAMC channels. It would be accompanied by a general invitation for expressions of interest by institutions in the possibility of participation

in a prototype project. Both institutions already funded for HMO development as well as those not yet supported are considered for prototype participation. On the basis of the communications received, the critiera for the particular prototype in which a school expressed interest could be sent to them along with a request for a prospectus which would set forth in detail their capacity and potential to meet the criteria. An expert committee assembled by the AAMC would then review the prospective submissions in terms of their qualifications in the light of prerequisite criteria. Ultimately HSMHA would make that determination as to the specific number and types of prototype projects to be supported under the program. AAMC in line with a contractual arrangement with HSMHA, would provide coordination, technical assistance and guidance in their planning and development. This would include assistance in the development of applications for prototype project planning grants and in the planning and developmental process itself, if an award is made by HSMHA.

Recommendations for Prototype Development

The eight HMO workshops conducted by the AAMC focused on the critical issues that the Steering Committee for each session saw as the most significant, insofar as effective application of the HMO concept in the academic health environment was concerned. Analysis of the eight workshop reports, including more than 40 presentations and transcripts or reports of many of the discussion groups at the sessions, indicates that the issues of primary general concern included:

1. The problems of structure and governance with particular reference to the relative degree of involvement and control by the university.

2. The problem of adaptation of the HMO modality which presumes a balanced population target group to the areas of geographic and socio-economic imbalance -- both urban and rural -- in which many university medical centers are located.

3. The recognition that the true importance and full potential of the university related HMO development cannot be realized unless effective integration of relevant educational and research programs is accomplished. Special reference in this regard is made to the subject areas of primary continuing comprehensive care and the essential components of the HMO process itself.

4. Fiscal problems - both those germane to the organization and operation of HMO's generally, as well as to a special set of problems unique to such projects in the university medical center environment.

On the basis of the foregoing considerations, the following recommendations are made:

1. One or more prototype projects of the following types should get priority consideration:

   a) A major collaborative effort with an HMO based outside the academic medical center. Special importance is attached to the affiliated community hospital in this regard.

b) A major HMO development within the university medical center that is designed to serve a population group representative of the general community.

c) A university related HMO model especially adapted to the problems of sparsely populated rural areas.

d) A university related HMO model especially adapted to the problems of densely populated urban areas.

2. A substantive prerequisite for prototype project qualification should be a demonstrated institutional commitment and capability to develop an effective and symbiotic relationship between the HMO and relevant educational and research programs. Particular reference in this regard is to the subject areas of primary, comprehensive care. In view of the existing fragmentation of funding sources, however, institutions should not have to struggle to meet this requirement alone. The AAMC and HEW should help to develop coordinated, conjoint plans for support of such integrated programs of service, education and research as proposed by the institutions sponsoring prototype projects.

3. Special consideration should be given in prototype projects to the particular problems of HMO development in publicly supported institutions.

4. Prototypes should be given ample funding to permit a thorough and comprehensive effort so that the benefit of the experiments in the planning and development of university related HMO's will be provided for the entire field. Special attention should be given to the application of cost accounting theory to the problem of identifying educational costs in the very complex joint-cost situation inherent in the HMO-university relationship. Such a focus could help provide for more accurate approaches to the determination of the "quality differential" of such care programs in the academic medical center and improved methodology for the identification and separation of the cost of service, education and research.

DISCUSSION: <u>The Critical Issue of Structure and Governance</u>

The question of the undertaking of a major involvement in HMO development raises very fundamental issues relating to the organization of the university and its governing processes and policies. Major attention to the analysis of these implications was given in several papers presented at the various workshops and other forums. [2,3,4,5,6,7,8]

On the basis of this consideration, the most frequent forms of university HMO involvement may be classified as follows:

University involvement with extramural HMO project

1. Community hospital
2. Citizens group
3. Medical group
4. Medical foundation
5. New community
6. Other entities

University involvement with intramural HMO project

1. Academic medical center
2. Other university locus

Within the above forms, a wide degree of variation is possible in the extent of involvement and control of the university with regard to the HMO. The range is from an HMO sponsored and operated by the university per se[10] to the integration of the university student health service into a community sponsored HMO project.[12] The pioneer university related HMO programs demonstrate this diversity.[2,13,14,15,16,17,18,19] For example, the Harvard Community Health Plan is run by a separate corporation controlled by the University; the East Baltimore Medical Program is an independent corporation with which Johns Hopkins Medical Group (a partnership controlled by Johns Hopkins) have a contractual agreement to provide health services; the Columbia HMO project of Johns Hopkins is based upon a contractual agreement between the Columbia Hospital and Clinics Foundation (a university controlled corporation), the above mentioned Johns Hopkins Medical Group and an independent corporation - the Connecticut General Life Insurance Company; the Yale Health Plan is a university family HMO operated by the University corporation which has a formal affiliation agreement with the Yale-New Haven Health Center (which includes the School of Medicine and the Yale-New Haven Hospital).

Another major concern under the governance heading that cuts across the classification spectrum is the question of whether the school is publicly or privately supported. All of the initial pioneering HMO efforts emanated from private schools but several public school sponsored HMO projects are in the planning or developmental stages. The workshops gave consideration to the special problems in this regard.[20,21]

A fairly sharp diversity of opinion emerged at the workshops over the relative merits of the different modes of university HMO involvement, particularly with regard to the matter of direct sponsorship and operation by the university as opposed to a "back-up" or other role with regard to an HMO under other than direct university auspices. More than a dozen speakers addressed themselves directly to one side or the other of this issue. Appropriately, Dr. I.S. Falk, one of the great pioneers of the prepaid practice field, effectively framed the two aspects of the question:

"If an Academic Medical Center is primarily oriented to teaching, training, and research in the accustomed and prevailing patterns, if the outlook is that it will be reluctant to change the emphases or the course of its interests, and if it is so situated that it has the privilege of making its own policy decisions, it nonetheless has a responsibility to examine its role with regard to the health care of the community. It should be or become knowledgeable about such needs from both the local and national standpoint. In the circumstances of the present times,it should accept an obligation to participate and assist in the design and development of needed community- based service organizations for the availability and delivery of medical care. Thus it could contribute to local area services, and to experimentation and evaluation on systems for the availability and delivery of medical care. Beyond that level, the Academic Medical Center may and indeed should participate, through formal affiliation, in making its resources for care available to community plans on mutually agreeable contractual terms. And still further, it should assist the community plans as in matters of recruiting needed staff, in plan operations, in service reviews and evaluation, etc.

In return, the Academic Center should accept the community plan as a source of patients for its education, training and research programs, and as loci for health manpower training in a group practice setting and for joint research and evaluation programs. But the Academic Medical Center should not itself undertake to sponsor, control, operate and finance continuing programs which - in the years ahead - are destined I believe to become the principal medical care delivery systems of the community.

However, if an Academic Medical Center has major interest or overriding obligations for patient care, locally or in a larger area, as may be the case for a state-supported medical center, it may have many of the same obligations and may also have to become heavily involved in sponsoring and in operating one or more HMO's or even a regional system of HMO's. It may nevertheless find many values in adapting the New Haven pattern,as by sponsoring or assisting the development of associated or affiliated community-based organizations serving many of the purposes that are served by the Community Health Center Plan in the New Haven design." [16]

The majority of opinions - and most of the university related HMO's in existence or under development - reflects a preference for the approach of involvement through affiliation with an extramural HMO entity - whether sponsored or independent in lieu of direct operation by the academic institution per se. [3,7,8.9,24,25] There is, however, a vigorous minority viewpoint.[10,20,26,27,28,29] The majority attitude stresses that the extramural approach facilitates the advoidance of what they consider to be inherent weaknesses of the direct institutional approach. These include lack of management expertise, conflict with educational and teaching goals, established departmental structures, faculty status and reward systems, lack of competence or interest in primary care, financial vulnerability, town and gown problems and difficulties of involving outsiders (consumers) in governance. On the other hand, the contrary view is largely based on the belief that with the extramurally related program - the interface with essential academic functions is more likely to be remote and therefore tend to dilute and attenuate the university participation. This school of thought believes that the intramurally based HMO is an effective approach to bringing about more substantial integration of the academic and service functions. In addition to those which expressed a specific point of

view some of the presentations simply assessed the relative assets and liabilities of the two approaches without indicating a preference for one or the other.[6,22,31]

A great deal of stress was placed by Workshop participants on the importance and necessity for a diversity of university related approaches to the delivery of care in general and HMO's in particular.

As stated in the Conclusions and Recommendations of the Southeastern Area HMO Workshop at Chapel Hill, "medical schools should be able to stimulate the creation of a variety of models appropriate to their ability to be involved. There was an apparent consensus at the Workshop that the HMO concept should be allowed to evolve in a number of ways." [25]

Closely related to this was the opinion that there ought to be experimentation by academic medical centers with new and innovative approaches that would provide experimental departures from the established Kaiser prototype HMO. One idea in this regard independently suggested by two different individuals of wide experience in the medical care field urged experimentation with an approach based on satellite primary care teams, related to, but not based at, an ambulatory care center in a prepaid gruop practice. [32,46]

On the basis of the foregoing it is difficult to limit the recommendations for the various prototypes for university medical center development. It would be desirable to have major prototype developments for each of the types listed in the above classification as well as some "new departure" innovative experiments. However, for the purposes of this report it is necessary to be selective and limit the recommended prototypes to a few amply financed and well developed efforts of the most generic application. For the reasons set forth below, two prototypes to offer guidance and insight on the critical problems of structure and governance are recommended - an affiliated community hospital based HMO and an intramurally based HMO.

The Affiliated Community Hospital Based HMO

A possible middle-ground approach of considerable promise which lies between the extremes of the intramural-extramural issues involved the affiliated community hospital teaching HMO. [11,21,33] As a collaborative endeavor of the university and an affiliated community hospital an HMO could avoid or at least mitigate many of the obstacles identified as possible constraints for such a program within the university environment as indicated above. On the other hand, such an arrangement would place the HMO in a service-oriented environment where there is both existing competence and interest. However, speical importance is seen in the fact that such a framework would have great potential for the development of a new dimension of community hospital based medical education in primary continuing and comprehensive care. Anne R. Somers, a member of the AAMC Health Services Advisory Committee, has articulated the major benefits of such an arrangement in recent articles. [34] It is envisioned that the program would provide a basis for a type of interface between the spheres of education and service to which the Carnegie Commission Report attached such importance. Such an environment would also be conducive to the improved integration of ambulatory and hospital type training - a problem with which educational efforts in freestanding ambulatory centers have experienced considerable difficulty. As a collaborative endeavor of two universities and the

community hospital it could foster a continuing sense of identification and responsibility in both entities, without dominance in either.

University Based HMO

With regard to the difference of views concerning direct operation of HMOs by academic institutions, it is noted that, except for the atypical "university family" type of program, the arguments on both sides are essentially a priori judgments. The only empirical evidence concerning an institutionally operated HMO serving a community population derives from the 318-family controlled study of the Washington University (St. Louis) School of Medicine. The program is now in the process of expansion to an operational scale of 25,000 enrollees.

The issue of locus of responsibility for HMO development within the university structure also evokes differences of opinion. The medical school based model of Washington University (St. Louis) is one type and represents a unique approach in the face of questions concerning the capacity of a medical school to effectively operate such a program as an integral part of the university medical center. In this setting, the HMO tends to assume for the primary care area the essential function that the university hospital serves for specialty, inpatient type care. A major aim is to maximize exposure of medical students and house officers to such a primary and comprehensive care program and thereby exert influence on attitudes and value scales in formative professional stages. A thorough institutional planning effort by the Division of Health Care Research at Washington University School of Medicine has carefully explored the anatomy of such an approach and defined the issues.[35] Such an innovative thrust should be encouraged to assure consideration of diverse parameters.

On the other hand, an expert consultant in reviewing a proposed plan for HMO development by an academic institution recommended against HMO development at the medical school level because he believed the objectives of the two organizations would conflict and would diffuse education and research efforts on the one hand and jeopardize the HMO effort on the other. In contradistinction, however, the university level was seen as an appropriate base. In this connection it was noted that the university administration is already involved in medical care in various ways including the provision of student health services, ocupational health services, and athletic health services, as well as financing health care benefits for faculty and employees as a fringe benefit.

In addition, such a university base for an HMO may also possibly afford a more effective axis for integration of central services (such as computer and transportation services) and the wide spectrum of scientific disciplines outside of the health sciences that are relevant to a project such as an HMO. These would include the fundamental social sciences such as economics, sociology, and anthropology as well as the political sciences, management engineering and business sciences. This is not to say that a university medical center based HMO could or would not achieve effective involvement of these relevant resources but rather that the university level represents a possible alternative. The importance - and in an oblique way the problem - of getting effective involvement of other disciplines in a medical school based endeavor is illustrated by the following quotations from Workshop Reports.

"It should be noted that this workshop intentionally concentrated on the medical school and the HMO. The sparse mention of other components of academic health sciences centers should not be interpreted to mean they should or could be forgotten as universities consider the HMO movement." [25]

* * *

"Throughout the evening discussion we shall assume the presence of an operational HMO in the medical school. We shall also assume the HMO is organized to permit the participation of undergraduate students in all of the health professions (medicine, dentistry, nursing, social work, medical administration and physician assistants) as well as interns and residents. For the purpose of this discussion, I shall confine my remarks to the education of medical students, interns and residents." [37]

* * *

For the foregoing reasons one or more prototype projects involving the university based approach are recommended. It is to be noted that the recommended prototypes are distinguished from those university HMO programs which are designed primarily to serve the university family population (i.e., faculty, students, employees) in the contemplation that they could be designed to serve a representative community population - either with or without the university component.

DISCUSSION: The Critical Issue of Target Population Imbalance

Two elemental components of the basic HMO concept are (a) the marketing capability to enroll an adequate number of members and (b) an enrolled group that is representative of the socio-economic mix of the community in general.[3] Since many university medical centers are located in densely populated urban areas with a heavy proportion of disadvantaged people[30] and in sparsely populated rural areas, it is necessary to give consideration to special adaptations of the HMO mechanism in the light of these circumstances.[38,39]

Urban Areas

The obstacles of developing a university related HMO in an inner city area are heavily economic, bureaucratic, and socio-political in nature.[3,23,40,41] The experience of the Johns Hopkins East Baltimore HMO project[15,41] puts into sharp focus the problem of obtaining support for enrollment of a population group from a disadvantaged area. The major difficulites involve (1) what are described in East Baltimore as the "nightmare" of attempting to relate to the eligibility, funding and regulations of a multiplicity of programs at all levels of government and (2) how to finance the enrollment of the medically indigent - the so-called "gray zone"people who are not beneficiaries of any governmental program but are too poor to pay.[23,24,39,40]

The socio-political aspects of the establishment of health services programs in disadvantaged areas by universities have been documentd by Drs. Geiger and

Gibson (primarily with reference to the Tufts Columbia Point and Mississippi OEO sponsored programs).[42,43] The issue of community involvement in governance poses many new problems under such circumstances and nature of the HMO approach which essentially prescribes a high degree of efficiency and cost control -- gives a new dimension of difficulty.[3,9,30,32,40]

It is clear that the university which can draw on a wide spectrum of relevant disciplines in the social, political and managerial sciences-- along with those of health -- has a latent potential to make a major contribution to the development of trail-breaking approaches to these problems.[32] Therefore, it has the potential capability of developing new and innovative societal mechanisms for the integration of multiple funding sources and agencies of government. Similarly it has the capacity to devise experimental approaches for funding care for the medically indigent. It is feasible for a prototype to develop and test methods not possible on a general basis and develop a sound basis of data and information from which permanent general application could be devised.[25] The same is true of consumer or community involvement. Despite the growing recognition of the importance of this aspect as reflected by the increasing tendency to write such a requirement into legislation and program regulations, there has been very little scientific attention given to the development of methodology and processes that can effectively accomplish this task.[38] Again the university has unique tools with which to attack this problem and special attention by HMO prototype projects is recommended. Some effective efforts in this direction which offered promising indications of this potential were described at the workshops - with particular reference to the programs at Southern Illinois University[12,44] and Temple University.[45]

Rural Areas

The problems of adapting the HMO concept to serving rural areas have been described by one of the consultants to the project as "exquisitely difficult." A major focus was put on the need in this regard by the Western Area Workshop at the University of Colorado.[31,37,49] In addition there were significant contributions at other workshops to the importance of this aspect such as that of the Univeristy of Kentucky at the Middle Atlantic Area session in Washington, D.C.[23] and at the Middle U.S. session at St. Louis.[31] While some of the fundamental issues (such as funding for enrollment of the medically indigent) tend to be the same as with the inner city program, the configuration of the problems in the rural area is distinctive. Here the demographic problems involve distances and the spread of the population, rather than density. The spectrum of problems embrace - in addition to new types of medical organization and personnel utilization - those in the field of communication, transportation and intergovernmental relationships. It was suggested that under such circumstances of scarce resources, sparse population and great distances the normal competitive choice characteristics of the HMO concept may not be feasible and some sort of franchising approach may be necessary.[31] In this regard, the fact that in most instances universities in such rural areas are state institutions with varying degrees of legal responsibility for that constituency may be a special factor in dealing with the problem. As such, the university may represent the only institution capable of accomplishing the task of bringing together the consortium of diverse resources and institutions necessary to such an endeavor. A rural prototype to guide developments in the field in this regard appears to be much needed.

DISCUSSION: The Critical Issue of Educational and Research Functions Relevant to Hmo Concept

HMO's and Educational Programs in Primary Care

While the issue of the form of university involvement evoked a strong difference of opinion among workshop participants one aspect of the substantive nature of that involvement brought forth a powerful and impressive expression of unanimity. This refers to the importance and priority attached to the need for strong educational programs for all the health professions (but particularly for physicians) in primary, continuing, comprehensive care geared to and based upon HMO and other type primary care programs.[4,23,27,50,51,52,53]

The case made may be summarized as follows:

a) One of the most crucial constraints on major growth and expansion of the HMO approach in the U.S. is the lack of an adequate supply of appropriately trained, oriented and motivated health professionals at all levels.[1,3,52]

b) The production of such health manpower services requires major emphasis on the development of educational programs in primary care for all levels of health professionals.[20,21,23,37,52,54]

c) Such educational programs must be based upon and geared to actual primary care programs such as an HMO.[5,10,37]

It is important to note that the HMO was not indicated as the exclusive mechanism of choice as a training ground in primary and comprehensive care. The consensus was that there ought to be a variety of mechanisms for teaching projects and one paper assessed the specific strengths and weaknesses of the HMO approach for the purpose.[53] However, the major point made is that the university needs such appropriate environments for effective development of primary care training and a university involvement in an HMO should be approached in the light of this vital need.[30,33]

Insofar as the HMO as a training base is concerned, a dilemma emerged with regard to the university related HMO program. The weight of authority indicated that such programs should not be burdened with teaching functions to a major degree until the program is well established both financially and operationally. Considering the normal preoperational lead time of several years plus an average of two or three years to reach the break even point, the deferment of substantial educational applications in this regard becomes a matter of concern. As pointed out, in the report of the Middle Atlantic Area Workshop, "this discussion highlights the irony that the primary purpose for universities to develop prepaid plans for defined populations was to reform and restructure the educational system."[23] In addition it was noted that university sponsored HMOs so far have developed only minimal educational applications.[23,33] A parallel point involves a strong consensus at the workshops to the effect that as a general role, university HMO projects should not merely involve the development of an operative HMO as a pruely service function.[38,55]

Full recognition was given to the great difficulties of integrating such a service program as an HMO with educational and research functions in the

academic setting. The workshops elicited opinions to the effect that there is a great lack of an adequate body of data and knowledge about the content and methodology for teaching primary, continuing comprehensive care. It was demonstrated that much more needs to be known in this regard about such things as team care and the functions and interrelationships of the physician's assistant and other allied health personnel in the actual ambulatory care setting such as the HMO.[23,50,56,57,58] The early findings of a project at the Mount Sinai School of Medicine to develop an educational program for medical students in a prepaid group practice setting gives promising evidence of the possibilities and potential in this regard.[59] More serious, however, were the indications of the lack of status and empahsis accorded primary care in educational programs of many university medical centers.[4,5,10,20,21,27,30,39,51,60,61] Therefore, it is proposed that to be a true prototype for this field, a project should exemplify the application of the unique and distinctive qualities and resources of the univeristy medical cneter to the effective implementation of the HMO concept. In this particular regard, prototype projects should address themselves to the solution of the dilemma of integration of educational programs with their HMO development effort.

It is to be stressed that this attitude is not to be taken as a dilution in any degree of the genuine and primary service commitment that is inherent to the HMO.[23,48] It is based on the conviction that the relationship should be fundamentally a symbiotic one of mutual interdependence. As one of the workshop papers put it, "There can be no debate whether the program priorities are education or research or service, but the belief that excellent education and research can only occur in the context of a program of excellent service, consistent with the realities of what people want and whay they will pay for."[52]

For the foregoing reasons, major linkage between university prototype HMO projects and an emphasis on the development of educational programs in primary and comprehensive care is strongly advocated.

HMOs and Research Functions

Workshops also put strong emphasis on the unique potential of the academically related HMO to develop and refine knowledge that is essential and urgently needed for the growth and development of the HMO concept.[1,4,8,54,65]

The target areas include the elemental components of the medical care process and the HMO conept, as well as clinical and epidemiological knowledge. The following are culled from the Workshop Reports:

> ...Pellegrino in keynoting the New York Workshop stressed the need to put forthright emphasis on definition, evaluation, teaching and affiliation of health maintenance. He pointed out that although the efficacy and economy of "health maintenance" measures were a major factor of appeal for legislative and public acceptance of the HMO concept that actually there was little known or done about them.[60]
>
> ...Heyssel and Carter at the Washington session pointed out that to effectively put new emphasis on the maintenance and promotion of health in the community requires different but no less scientific approaches to generate new knowledge concerning: the impact of social settings on

health, the effectiveness of health education campaigns on population; the appropriate roles in maintenance and promotion of health for both new health professionals and traditional health counselors.[52]

...Kass at Chapel Hill dramatically identified a number of important disease entities for which effective treatment is limited by lack of knowledge about their natural history - a type of biomedical data that cannot be adequately studied in hospitalized populations and which requires an HMO type of population group.[62]

...Brook[63] and Anderson[64] at the Pacific Coast Workshop focused on the problem of quality and assurance and revealed some of the limitations in existing technological capability in this area, as well as some practical approaches. In view of the increasing attention being given to this issue in legislative proposals, administrative regulations and professional circles, the need for attention in this regard is very clear.

The New York area meeting gave special emphasis to the relevance and relationship of research functions to an HMO program in a university setting. In a special panel on the subject, Shapiro of HIP pungently pointed out that "our lack of knowledge about the natural history of disease can be matched by the inadequacy of our information about the natural history of medical care and the factors that effect it." He described the current state of understanding about patterns of care and health status as "primitive." He also saw the great value that a series of prototype projects could have through the provision of parallel sets of data which would permit more meaningful patterns of utilization of health services and health status.[56] McGuire in discussing the issues of educational research applications stated "...because of the very nature of the target population for whom the HMO is designed, I believe that involvement of the academic community in such programs will, for the first time, enable the educational researcher to determine the real relation between the criterion of effective education and the ultimate criterion toward which all education is directed, namely the effectiveness of health care delivery."[57] Friedson, in discussing the behavioral aspects, also found serious gaps in knowledge fundamental to the understanding and assessment of the HMO delivery system. He cited how little we really know about the actual work of the every day practitioner and about how interoccupational teams operate and perform. He closed his analysis with the following statement:

> "Finally, there is the issue of government of the HMO. Actually apart from administrative anecdotes and personal memoirs, we have very little information at all as to how medical practices, group or individual, are governed. How actually are formal rules and regulations carried out? What exactly is the relationship of the administration to the medical staff? How much can the administration be said to govern rather than keep house, and how does the administration gain influence over medical staff behavior?"[58]

All of the above mentioned items have in common the fact that (a) a very little is known about them; (b) the need to obtain knowledge is urgent; (c) the university medical center has appropriate capacities; and (d) an HMO-type setting is essential. Therefore, university HMO prototypes should be designed for compatibility with the above indicated research functions that are of prime relevance to HMO development.

DISCUSSION: The Critical Issue of Fiscal Constraints

The major critical barriers of a fiscal nature include:

a) The fundamental necessity of an effective linkage between entitlement for care with development of delivery mechanisms such as the HMO is a major expansion of the approach is to be effectively accomplished without reinforcing the two-class system of medical care.[23,39]

b) A need to provide for a substantial incentive to foster academic medical center involvement in HMO type programs.[24]

c) The essential importance of assurance of continuity of support to protect institutional integrity after having been lured into accepting responsibilities that are financially of a serious magnitude and from which extrication is not easy.[65]

d) The economic impossibility of saddling university related (or any other type) HMO's with an open enrollment requirement.[32,40,66]

e) The problem of separating education from service costs in the very complex situation inherent in the HMO-university relationship.

With the exception of the last item listed, the solution to the above mentioned critical fiscal issues requires action that is well beyond that of funding a limited number of prototype university HMO projects. Major legislative and administrative steps would be required. It is possible as indicated below, however, through the medium of the prototype projects to acquire a sense of direction and to develop and test some mechanisms or approaches. For example, while categorical support for the "gray zone" population is not yet genuinely possible, it will be feasible to work out a pilot approach for prototype project purposes in connection with the urban and/or rural models.

A special note is in order with regard to the university incentive factor mentioned in item (b) above. The workshops were unanimous in stressing the importance of building sound footings for such projects by a thorough planning process that addresses itself in a substantially objective manner to the complex issues of human and organizational behavior, involving a variety of groups (family, students, practicing physicians and consumers) that such a unconventional or new type program as the university related HMO necessarily involves.[25] Without special support, an HMO development effort in the academic environment may very likely be understaffed and underfinanced. An academic entrepreneur trying to float a proposal that goes against the traditional grain of the institution encounters strong pressure to avoid or insulate some of the highly complex and controversial factors. Therefore, a thorough planning process involving the development of objective, analytical data and full consideration of long-run implications, so desinged as to develop a real sense of institutional understanding and commitment to the undertaking is considered essential. Such a scientific and systematic approach is much more expensive and time consuming than the intuitive or evangelical approach but in the long run will assure sound development in a situation where misguided or superficial approaches can do serious harm to both the institution and the community. It has been stated by some not familiar with the academic situation that planning for a university medical center related HMO is less expensive because many of the facilities or resources required for an HMO

are already available. Even from a technological standpoint, this is a misguided view - but from the aspects of human and organizational behavior mentioned above it is a serious distortion. The problems are complex and difficult, and the planning effort must be commensurate. The implication is that prototype HMO planning and development should be adequately funded so that they can provide an example and guide which will lead to the effective development of such programs throughout the field.[65]

The Special Problem of Cost Analysis

The problem of separating the interwoven costs of service, education and research in the academic medical center is one to which considerable attention was given at the Workshops in general recognition of its importance. It has become a major issue in health insurance regulations in Pennsylvania, New York and elsewhere. Significant problems in Medicare reimbursement have arisen over this point. The emergence of the HMO on the academic scene raises a new dimension of the problem. As a frankly service operation in which the enrollee purchases a package of benefits for a certain premium, it is fundamental that the tendency to pass the costs of education off in the service bill cannot operate in this situation. The problem is compounded by the lack of information on the primary care process in the academic setting or the relative magnitude or values of service and educational aspects. On the other hand, as pointed out by Dr. Falk in the workshop discussion at Yale, a new HMO is a well-defined entity, a contained system with a prospective budget developed on an actuarial basis relative to utilization data. The addition of training functions involves the problem of giving opportunities for persons in training to participate, under supervision, in the provision of service, however, this is measurable in terms of training time and supervisory time. It involves additional increments of space, overhead and supporting staff, all of which are definable elements on which price tags can be put.[47] In summary, an important special objective of HMO prototype projects should be the development of cost analysis methodology designed to identify and apportion the service, education and research costs of such university related programs. This may also be helpful in developing some improved approaches to the measurement of the "quality differential" of operating care programs in the university medical center setting.[48]

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69. Cander (37), Johnson (29), Levine (27), Lyon (7), Perkoff (10), Piemme (2), Saward (3), Sheps (25), Spiro (26), Thompson (11), Thurman (28), Wilson (9), Yedidia (40).

GRADUATE MEDICAL EDUCATION COMMITTEE MEETING

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

July 20, 1972--10:00 AM - 4:00 PM

AGENDA

The Committee is charged with the responsibility of furthering the implementation of the AAMC's position regarding the responsibility of academic medical centers for graduate clinical education. This first meeting will be devoted to discussing the implications of the AAMC position and developing strategies to accomplish the Committee's work. Copies of the position statement and the reprint from JME on the implications as articulated by a previous committee are enclosed. Possible strategies are detailed below:

1. There is no document equivalent to "Functions and Structure of a Medical School" for insitiutionalized graduate medical education. Should the Committee draft a document describing the optimal arrangements for an insitituion's taking full responsibility for graduate medical education? The newly-created Liaison Committee on Graduate Medical Education and the Coordinating Council for Medical Education ultimately will have to wrestle with this. Preliminary work might be worthwhile. A copy of the latest draft of "Functions and Structure of a Medical School" is enclosed.

2. The anomalous position of house officers as both students and practitioners creates great confusion regarding their status. Should the Committee attempt to develop arbitrary definitions and allocation of their efforts? Clarification of how much they are teaching faculty is becoming important--this is particularly pertinent in resolving issues related to financing graduate medical education.

3. At least two medical faculties (Case-Western and Colorado) have accepted the AAMC position in principle. Should the Committee seek to meet with representatives of those faculties in order to gage the problems which must be overcome and gain information regarding the schools' perception of the assistance needed from the AAMC?

4. The Liaison Committee on Graduate Medical Education and the Coordinating Council will soon be operational (some-

time next winter at the latest). How can this development be used to further institutional assumption of responsibility for graduate medical education? Copies of the agreements creating the Liaison Committee and the Coordinating Council are attached.

5. There is considerable public concern regarding the balance of specialists in medicine and surgery. Does the AAMC position on Graduate Medical Education provide a foundation to move toward insuring a better balance in the output of specialists or does further effort need to be made toward developing a nationally effective policy for the institutions?

ENCLOSURES:

1. Position Statement on Graduate Medical Education
2. Implications Reprint
3. Draft of "Functions and Structure of a Medical School"
4. Residency Requirements
5. Agreement on Liaison Committee on Graduate Medical Education and the Coordinating Council
6. "Manpower Needs by Specialty" by Henry R. Mason, MPH, JAMA, March 20, 1972. Vol. 219, No. 12.

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MINUTES

RMP-CHP COMMITTEE
Thursday, June 15, 1972
AAMC Conference Room
Washington, D.C.

Present

Stuart M. Sessoms, M.D., Chairman
William S. Jordan, Jr., M.D.
Alexander M. Schmidt, M.D.
James V. Warren, M.D.

Absent

William H. Stewart, M.D.

Guest

William R. Willard, M.D.

AAMC Staff

John A. D. Cooper, M.D.
August G. Swanson, M.D.
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Stephen J. Ackerman
Grace Beirne
Prentice Bowsher
Rosemary Wilson
Alexa Burt

The RMP-CHP Committee of the AAMC, chaired by Dr. Stuart Sessoms, held its first meeting on Thursday, June 15, 1972, in the AAMC conference room in Washington.

1. Dr. John A. D. Cooper opened the meeting with a discussion of the background and purpose of the ad hoc committee's task. It was pointed out that Senator Kennedy's HMO bill S.3327 had drawn attention to the fact that the authorizations for both RMP and CHP would be expiring within a year and some legislative action with regard to them would be forthcoming. Consequently, it is important that AAMC address itself to these events in order that it may be prepared to state its position and exert its influence on the legislative issues when they arise. Some prime questions for committee consideration included: a) what do RMP and CHP do now and how does it affect the AAMC constituency? b) what do we think RMP-CHP should do and how should it affect our constituency? and c) what steps are necessary to achieve these ends?

2. Dr. William Willard was invited to meet with the committee because of his special background as chairman of a committee which was appointed by Dr. Vernon Wilson soon after his appointment as Administrator of HSMHA to make a study of the RMP-CHP problems and submit recommendations. The report has never been officially released. Dr. Willard discussed the background and philosophy of the Willard Committee's approach: essential policy concepts of the group were to build on what was existing but work toward defined goals for 10-20 years in the future. He cited some of the important factors at the time that affected the development of the report, including an Administration legislative proposal (The Health Services Improvement Act) which dealt with the interrelationships of the programs;

an HEW-HSMHA policy of decentralization of authority to the regional offices; and the emergence of the National Center for Health Services Research and Development as a third element to the RMP-CHP overlap. In the light of Dr. Willard's special knowledge and contributions to the committee, Dr. Cooper wanted him to become a regular member of the committee, and Dr. Willard agreed to serve.

3. There ensued a general discussion of the RMP-CHP situation. The ideas and issues mentioned included:

a. The relationship of the RMP program thrust to its original categorical focus and to the new legislative authorization in the Cancer and Heart and Lung disease areas was discussed.

b. An underlying issue emerged with regard to whether improved combination of the existing RMP-CHP entities (such as having RMP represented on the CHP Board) can solve the problem or whether constitutional deficiencies in both of the programs require more substantive approaches.

c. The lack of an adequate regulatory authority in the states and the possibilities of organizational structures for such a purpose were indicated as fundamental concerns.

d. The need for trained manpower in these programs was recognized as a major problem.

e. An important issue involves the policy view of CHP being concerned only with planning and without decision-making authority. The Willard Committee sought to change this by adding some decision-making power.

f. RMP-CHP represent Federal programs set down in the States--the issue of self-determination vs. federalization is involved here.

g. Both RMP and CHP over time have developed strong constituencies--a factor to be dealt with in attempting to bring about change.

h. The caliber of staffing and funding levels of CHP have been inadequate.

i. The relative weakness of State health agencies, which, in a sense, represent existing "State authorities," was identified as a part of the problem. On the other hand, it was observed that medical schools had not done much in the way of encouraging the interest of students in the field of public health.

4. Dr. Cooper suggested an approach to the problem through listing the defects of the health care system and the possible solution to them in the light of the goals for twenty years ahead. In general discussion with the committee, he developed these listings:

I. Characteristics of the Health Care System

A. Accessibility
1. Quantity
2. Location
3. Organization
4. Price
5. Consumer education

B. Quality

1. Biomedical
2. Acceptability

C. Financing

II. Defects of the Health Care System

A. 20×10^6 people do not have access [CHP]

B. Services located for convenience of providers and not consumers [CHP]

C. Insufficient use of professional people and structure resources [RMP]

D. Consumers not educated about their health--when they need to and how to get into the system [RMP]

E. Price escalating faster than other services [CHP]

F. Biomedical quality highly variable and not audited [RMP]

G. Impersonal service

H. Episodic curative medicine emphasizing manipulative procedures rather than preventive health care and promotion [RMP & medical centers]

I. Incomplete knowledge about disease [NIH & medical schools]

J. Insufficient number of health professionals

III. The Cast of Players

A. Consumer

B. Professional associations

C. Professionals

D. Insurance carriers

E. Medical centers

F. Local governments (city health departments) [CHP(b)]

G. State governments

1. Department of Health } CHP(a)
2. Politics } RMP

H. Federal government

1. NIH
2. HSMHA
   a. RMP
   b. NCHSRD
   C. NHSC

3. Congress
   a. Health subcommittees
   b. Finance
   c. Appropriations

IV. Solutions

A. For lack of accessibility

1. In each region determine causes of inaccessibility [CHP with help of RMP]
2. Recommend mix of:
   a. Incentive [CHP $; RMP other]
   b. Control (people & facilities) [CHP]
   c. Education [RMP]
   d. Transportation [RMP]
3. Involving:
   a. People
   b. Organization
   c. Location

B. Quality

1. Definition of objectives of health care system [CHP & RMP]
2. Quality of education of health professionals [medical centers, NIH, & other educational educational institutions; CHP?]
3. Advancing biomedical knowledge
4. Audited performance, including commission and omission (POMR) [RMP]
5. Continuum of education [medical schools & RMP]
6. Certification & recertification (relicensure) [state medical licensure board]

C. Acceptability

1. Consumer education [CHP, school systems, medical center design]
2. Consumer input into decision-making
3. Provider input into decision-making

5. Dr. Sessoms summarized the considerations of the session and programs of future action for the committee. These included:

a. Review of current laws governing RMP-CHP, copies of which were distributed; consideration of possible changes in legislative authorizations.

b. Identification and review of situations where effective integration of RMP-CHP effort had been achieved. It was suggested that AAMC staff consult with Dr. Marguiles and Mr. Peterson of RMPS-HSMHA and assemble some information in this regard. Visits to representative programs were suggested.

c. Other suggested sources of input to the committee effort included: the Chairmen of the RMP Coordinators' Association and his CHP counterpart; the AMA (Dr. Russell Roth specifically); Steve Lawton of Congressman Rogers' staff; and Dr. Vernon Wilson of HSMHA. It was decided to invite Dr. Wilson to the dinner at the next meeting of the committee and defer involvement of the others until the appropriate time.

6. The next meeting was set for September 7 in Washington with a dinner session on the evening of the 6th.

2nd draft 7/13/72

DRAFT FOR COUNCIL OF ACADEMIC SOCIETIES
WORKSHOP ON INDIVIDUALIZED MEDICAL EDUCATION
AGENDA

INFORMATION ITEM - VII

COUNCIL OF ACADEMIC SOCIETIES

INDIVIDUALIZED MEDICAL EDUCATION

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

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

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

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

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

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

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

Can individualization be made more cost effective if schools promote exchange-student programs, thus providing additional enrichment of student opportunities without excessive course development in each institution?

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

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

These are only a few of the questions raised by current trends toward increased flexibility in American medical education. The workshop will bring together representatives from 51 member societies of the CAS and representatives from the

medical schools, particularly those charged with the administration and management of innovative programs.

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

Although precise outcomes regarding identifying national needs for facilitating individualization cannot be predicted, it is likely that the conference will point up specific areas for special attention. Secondarily, special studies may develop to promote improvement of flexible programming in both undergraduate and graduate medical education.

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

2nd draft 7/13

CAS WORKSHOP

Preliminary agenda

Thursday

6:00 p.m. Reception

7:00 p.m. Dinner

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

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

Friday

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

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

9:00 a.m. Discussion

Friday, cont.

9:15 a.m. "Experiences and Outcomes at the Ohio State Pilot Medical School" _____ - Ohio State

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

9:45 a.m. Discussion

10:00 a.m. "Experience and Outcomes With An All-Elective Curriculum at Stanford" _____ - Stanford

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

10:30 a.m. Discussion

10:45 a.m. Coffee break

11:00 a.m. "Experiences and Outcomes with Early Career Tracking at _____"

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

Friday, cont.

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

11:30 a.m. Discussion

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

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

12:15 p.m. Discussion

12:20 p.m. Lunch

Friday, cont.

2:00 p.m. Workshops Convene

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

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

WORKSHOP #1

Developing An Array of Electives Which Meet Student Needs

A representative from Stanford

A representative from _____

L. Thompson Bowles, M.D., Recorder

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

WORKSHOP #2

Academic and Career Counselling

A representative from

A representative from

Roy K. Jarecky, Ed.D. - Recorder

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

WORKSHOP #2, contd.

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

WORKSHOP #3

The Present Need and Future Means for Assessment of Achievement

A representative from NBME

A representative from NTIB

James B. Erdmann, Ph.D. - Recorder

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

WORKSHOP #4

Self-Instructional Program Development

A representative from Southern Consortium

A representative from _____

William G. Cooper, Ph.D. - Recorder

WORKSHOP #4 contd.

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

WORKSHOP #5

Articulation With The Undergraduate College Experience

A representative from _____

A representative from _____

Davis G. Johnson, Ph.D. - Recorder

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

WORKSHOP #6

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

A representative from _____

A representative from _____

Michael F. Ball, M.D. - Recorder

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

ate clinical
WORKSHOP #6 contd.

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

5:30 p.m. Workshops adjourn

6:30 p.m. Reception

7:30 p.m. Free evening

Saturday

8:30 a.m. Workshops reconvene for summary discussion and final report preparations

10:00 a.m. Coffee

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

11:45 a.m. General discussion

12:30 p.m. Adjourn

INFORMATION ITEM - VIII

SUMMARY OF INVITED WORKSHOP on MODIFICATION OF MEDICAL COLLEGE ADMISSION TEST PROGRAM

On March 21 and 22, 1972 a workshop was organized by the Division of Educational Measurement and Research (DEMR) of the Association of American Medical Colleges (AAMC) at its offices in Washington, D.C. to discuss a proposal for a program of pre-enrollment assessment that would offer better measures of professional aptitude, readiness, and promise of medical school applicants than the current Medical College Admission Test (MCAT). This meeting was chaired by Dr. Hilliard Jason, professor and director, Office of Medical Education, Research and Development, Michigan State University. Other participants included: Dr. William Sedlacek, Counseling Center, University of Maryland; Dr. Alvin Beilby, premedical advisor, Pomona College; Dr. Lester Kieft, Chemistry Department, Bucknell University; Dr. John Caughey, Associate Dean, Case Western Reserve School of Medicine; Dr. Robert Tuttle, Associate Dean, Houston Medical School; Dr. William Schofield, University of Minnesota Medical School; Dr. Thomas Piemme, General Medicine, George Washington University; Miss Christine McGuire, College of Medicine, University of Illinois, and Mr. Mark Cannon, Medical College of Wisconsin; plus AAMC staff. These participants represented expertise in medical school admissions and curriculum, medical education research, non-cognitive assessment, issues concerning minority admissions, and the perspectives of medical school faculty, pre-professional advisors, and students.

In his opening remarks, Dr. John Cooper, President of the AAMC, talked about the necessity for undertaking an examination of the current MCAT. He stated that the MCAT and other such measuring devices needed to move with the times. This must be done in order to make sure that the instrument serves

the purposes of admissions as effectively and efficiently as possible. Dr. Jason continued this theme by noting the movement to a more flexible curriculum in medical schools, as evidenced by the appearance of electives, actual alternative tracks, and some schools talking about a totally individualized curriculum.

The workshop participants exhibited unanimity on the pressing need for modification in the MCAT program. The previous motivation of the MCAT and admissions policies was to assure survival in medical school. MCAT was designed to help stem the high attrition rate. The preoccupation with survival in medical school is no longer as current or as appropriate. One can no longer predict what the first year courses will be for a medical student, and the attrition rate in general has changed very favorably. Medical schools are to a large degree no longer faced with the problem of omitting the worst students. They now must choose from many fully qualified applicants those students they feel will be most compatible with their program of medical education. The MCAT was never designed for this job; therefore, it is now necessary to develop new ways of helping the medical schools cope with this task.

The Workshop participants agreed that a battery of tests must be developed to expand the current MCAT. It was recommended that such a testing program might include the measurement of:

(a) general aptitude for professional studies

(b) achievement in specific academic areas

(c) the cognitive aspects of clinical performance

(d) the non-cognitive aspects of clinical performance and practice characteristics

Particular emphasis was placed on the need for a systematic investigation of the non-cognitive domain. Variables, such as interests, motivations, attitudes have long been considered important in the selection process, but little in the way of empirically validated correlates of clinical performance and practice characteristics has been available to admissions officers. As a first step in this direction, the participants expressed the hope that the AAMC would explore the possibility of using a biographical inventory within the process of selection. Such an inventory would in addition serve a data gathering function and would range from the purely descriptive characteristics level to a non-cognitive measurement level, e.g., "How well do you work under stress conditions?"

The achievement component of the new program should include a section devoted to the Natural Sciences. Testing in this area would include physics, chemistry (organic and inorganic), and biology. It was suggested that admission committees be provided with several measures in this section so that a profile of strengths and weaknesses, rather than a single index of achievement, becomes available. Each medical school would then have the option of determining the kind of profile that would be acceptable.

The achievement component should include the behavioral and social sciences instead of the General Information Subtest of the current MCAT. Thus, the student would be required to answer questions dealing with issues such as the psychology of individual and group processes instead of cultural information.

The new program would include communication skills, such as reading, listening, and observing. It would also assess problem solving skills. This area would attempt to get at an individual's capacity to gather data, to

separate relevant from nonrelevant data, and to piece these together into hypotheses -- essentially, to exhibit some of the competencies that are required for dealing with clinical problems.

The area of symbolic reasoning was also suggested for possible inclusion in the test battery. Such an area would hopefully indicate to an admissions committee whether the student has the capacity for thinking abstractly. The consensus of the group, however, was that the area of symbolic reasoning was an item worthy of research and study, but they were uncertain as to how soon it could be ready for implementation.

A recurring concern of the participants throughout the workshop was the issue of specific provisions for minority candidates in the testing program. Several specific variables, especially of a non-cognitive kind, were identified for exploration as having enjoyed some predictive success in similar settings. In addition, it was recognized that the offering of a broader basis for selection and making possible the identification of specific strengths and weaknesses in prior achievement would be in the best interests of minority candidates as well.

In addition to identifying the components of the new test battery, the workshop participants recommended the use of "criterion referenced" measures instead of the commonly used "norm referenced" scores. Criterion referenced measures report performance in categorical terms, e.g., "adequate, borderline, inadequate," instead of numeric scores. Furthermore these measures result from judgments against an accepted standard of performance with specified required levels of competence. On the other hand, norm referenced scores are based on the performance of the group to which the individual can be considered

to belong. An individual's performance is reported in numbers that indicate his relative position in the group. The current system of reporting scores tends to create an illusion of precision and meaningfulness which is not claimed and cannot be supported by evidence. That is, admissions committees can succomb to the temptation to behave as though there were a real and valid difference between a score of, say, 595 and one of 565, or between 525 and 495. In point of fact, the instrument was not designed to render those kinds of distinctions, and should not be used in that way. The crucial issue, in the view of the workshop group, is in determing the approximate level of scores that provides reasonable assurance that all candidates above that level should be capable of performing satisfactorily. This is the kind of information "criterion referenced" measures are particularly designed to provide. The burden is then on the system to find other methods for distinguishing between the excess number of applicants who all meet the defined criteria, within the domain of aptitude of achievement testing. This implies a major effort to identify and justify additional cognitive and non-cognitive criteria not under systematic scrutiny today.

A final but by no means less urgent recommendation of the Workshop dealt with the necessity for an educational program to accompany any program of pre-enrollment assessment. Such a program would be designed to help users of the tests deal as effectively as possible with the information provided and must be developed simultaneously with the tests.

As a consequence of this input from the Workshop, the responses to the "Proposal for a New Program of Pre-enrollment Assessment" distributed in in March, '72, and the continuing flow of reactions from interested parties,

the dimensions of the DEMR's effort are being identified more clearly.

In short, these involve the development of achievement tests in the behavioral and social sciences; the development of a biographical inventory broadly defined to include other non-cognitive dimensions; the design and development of an educational program for the users of the test; a general exploration of the various systems of performance reporting, particularly criterion referenced measures; and the development of materials related to the cognitive and non-cognitive aspects of clinical performance.

While these are emerging as the major thrusts of the Division's efforts at the present time, the continuing input of all interested parties will be appreciated and deliberately sought.

LONGITUDINAL STUDY OF MEDICAL SCHOOL STUDENTS OF THE CLASS OF 1960

A status report prepared by Ayres D'Costa
August 1972

Background

The AAMC longitudinal study involved 2821 entering freshmen from 28 medical schools in 1956. A comprehensive battery of cognitive and non-cognitive tests was administered over the 1956 to 1965 period which provided motivational, achievement, school environment, and biographical information. Certain measures were administered both in 1956 and in 1960 in order to measure changes attributable to medical education. Additional data was also compiled on the undergraduate institution and medical school attended.

The original purposes of the study stemmed from a national concern for the expected vast increases in the numbers of students seeking higher education (Hutchins, 1964). Specifically the study was expected:

1. To improve medical students selection by considering other variables besides academic ability,
2. To understand and predict career choice patterns among medical students,
3. To understand student personality changes as a result of their medical school experience.
4. To understand educational environment differences in medical schools,
5. To examine criteria of physician performance in terms of their relationship to early student and environmental characteristics.

71-72 Project Objectives

Over the period October 1, 1971 to September 30, 1972, the AAMC, with collaboration from the University of Missouri (Dr. Edwin Hutchins) and the AMA, has been under contract with the National Center for Health Services Research and Development to produce the following:

1. An archive of data reports on the study,
2. A computerized data bank available to qualified researchers,
3. A strategy and options plan tailored to the current needs of society and the design of the study,
4. A detailed blueprint with materials necessary for a major fifteen-year follow-up study designed to link professional performance characteristics with early medical education variables.

Current Status of Project

An archive of nine volumes is now available to researchers. It contains all available (published or otherwise) research, data reports, and other materials pertaining to the longitudinal study. A table of contents has been prepared which will be published and distributed depending upon funds. Attempts have also been made to develop an annotated bibliography and an index to the archives.

All data pertaining to the original study is now on tape as part of a computerized data bank. Documentation manuals describing each variable its interpretation, and the context in which it was measured, are being finalized. A non-technical manual will be developed for potential researchers. The AMA has collaborated by providing its data on the current professional characteristics of the longitudinal study physicians. A Supervisory Board involving the AAMC and the AMA has been set up to ensure that appropriate confidentiality controls and research standards are maintained by this data bank.

A strategy and options plan for future research and follow-up for the study has been developed. Several broad strategies have been outlined and efforts are still underway to describe these in sufficient detail but without stifling the creativity of future research efforts with the study.

The major direction of the study has been slanted towards relating early medical education to later professional performance. A workshop of currently available physician performance measures was held in June 1972 which resulted in a clear mandate to follow-up the study group and suggested several approaches to performance measurement. A state-of-the-art paper and bibliography on physician performance has resulted from these efforts. The longitudinal study provides the opportunity for a focussed effort to tentatively accept a reasonable physician performance definition and to test it with the power of the currently available data bank. It is cautioned, however, that the longitudinal study will not resolve all the problems of physician performance measurement.

The Future of the Longitudinal Study

Discussions are currently underway with the NCHSRD for the funding of future phases of the project. It is recognized that all possible care and preparation must precede the actual follow-up. Accordingly Phase II (1972-73) will be dedicated to taking advantage of the currently available data bank in order to set up research hypotheses or professional performance questions relevant to current health care needs. Given this focus and clarification, Phase III (1973-75) will embark upon getting the instruments and procedures ready for the follow-up.

The future of the longitudinal study depends upon the collaborative efforts of all concerned. It is hoped to develop a consortium that will coordinate the efforts of medical education planners, research strategists, and funding agencies so that maximum benefits are derived from this national resource.

Report on Recent Internal Revenue Service Rulings Regarding Taxability of Research Fellowship Stipends

On May 30, 1972, the Internal Revenue Service (IRS) published Revenue Ruling 72-263 (Attached) announcing its determination that "A stipend paid by the National Institutes of Health to a physician for postdoctoral research training at a medical school is not excludable from gross income as a scholarship or fellowship." In reaching this determination, the Service cited court decisions holding that "a stipend is not a scholarship or a fellowship within the meaning of Section 117 of the Code if the grantor requires a quid pro quo from the recipient in the form of rendition of services for the grantor." The following facts were adduced in support of the conclusion that NIH is bargaining for research services and a research product rather than seeking to primarily benefit the education and training of the recipient in his individual capacity:

- -Selection is based on the recipient's potential for research,
- -The amount of the stipend is determined in relation to the recipient's relevant experience,
- -NIH reserves the rights to make royalty-free use of any copyrighted material produced as a result of the research, and
- -NIH has reserved patent rights to any invention arising from the research.

This determination is in conflict with the understanding of the NIH as to the taxability of the stipends and Dr. Marston has registered his concern with the HEW Office of the General Counsel that it "seems to have been arrived at through an apparent misinterpretation and misstatement of NIH program purposes." The ruling, he said, "challenges our long-standing expressions of the purposes of NIH stipend support, and has serious implications for understandings established over many years of NIH fellowship and training grant activity." Dr. Marston's memorandum lays out the NIH position and summarized the fundamental disagreement as follows: "1) NIH is not bargaining for a research service or a research product; 2) NIH does seek primarily to benefit the education and training of the recipient; and 3) NIH neither seeks nor expects a quid pro quo relationship with the recipient of stipend support." He concludes with the hope that NIH interests in future progress in health sciences research, training, and service "may continue unhindered by the disincentive which faces fellows and trainees if the IRS Rev. Rul. 72-263 be allowed to stand."

It is at this point unclear whether the Department of HEW will strenuously seek the retraction of the ruling by the IRS or if undertaken, what the likelihood of success is. The AAMC is advised by its attorney, however, that the ruling has the force of

law until retracted or overtuned in court. With regard to this latter possibility, it should be noted that it is IRS policy to enforce its rulings, even though they have been successfully challenged in court, in every jurisdiction which has not ruled against the Service. Thus a successful court challenge would have a very limited effect unless the matter were ultimately resolved by the U.S. Supreme Court!

In the interim, compliance with the law will require that the stipends be treated for all purposes as taxable income. This, of course, requires the deduction of income and social security taxes by the appropriate agency.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

JUN 1 1972

for possible use in AdBd agenda

Retain—6 mos. ☐
5 yrs. ☐
Permanently ☐
Follow-up Date

Kathy ? Joe

DATE June 6, 1972

TO: FOR THE RECORD

FROM: August G. Swanson, M.D.

SUBJECT: ABMS meeting on May 31, 1972

At the American Board of Medical Specialties meeting in Chicago on May 31, the resolution shown below was introduced during new business. Although the resolution was prepared by Dr. Kinney and myself; it was introduced by Dr. Beattie, who is one of the two representatives of the ABMS to the NIRMP.

After a brief discussion the resolution was passed, however the vote was 21 to 28. The narrowness of the margin for passage is disturbing and indicated that many of the specialty boards have little interest in maintaining the integrity of the NIRMP.

> The American Board of Medical Specialties affirms its support of the NIRMP. By this affirmation the ABMS supports the requirement that all graduate training programs recruiting students immediately after being granted their M.D. degree must utilize the Matching Plan in selecting such students. The ABMS strongly urges that all of its member agencies join in supporting this affirmation.

AGS:ba

COPIES TO: Top staff
Division heads of the Department of Academic Affairs

Status of Current Legislation of Interest

ISSUE	HOUSE	SENATE	OTHER ACTION
Institute of Aging 5887, HR 14424	Passed 7/18/72	Committee Approved 6/21/72	
Cooley's Anemia HR 15474	Passed 8/1/72	Passed 8/9/72	
Medical Libraries Act S 3752		Committee Approved 8/10/72	
V.A. Medical Care HR 10880	Passed 10/4/71	Passed 5/4/72	
National Health Insurance	Hearings Concluded	Hearings Recessed	
HMO'S S 3327	Committee Revising	Committee Approved 7/21/72	
V.A. Appropriations HR 15093	Passed 5/23/72	Passed 6/14/72	Cleared 8/3/72
Welfare/ Social Security HR 1	Passed 6/22/71	Committee Revisions Concluded	
Military Medical Schools HR 2	Passed 11/3/71	Passed 6/6/72	Conference Agreement Reached 8/3/72
NIH Appropriations HR 15417	Passed 6/15/72	Passed 6/27/72	Vetoed Veto Sustained

Status of Current Legislation of Interest

ISSUE	HOUSE	SENATE	OTHER ACTION
Dept. of Human Resources	Hearings Recessed	Hearings Recessed	
Dept. of Health S 3432 HR 14199			
V.A. Medical School Aid HJRES 748	Passed 7/19/71	Passed 4/27/72	
Heart Disease S 3323 HR 15081	Passed 7/18/72	Passed 4/7/72	Conference Agreement Reached 8/3/72
Sickle Cell Anemia S 2672	Passed 3/22/72	Passed 12/8/71	Signed 5/16/72 PL 92-294
Emergency Medical Care	Committee Revising	Committee Approved 6/21/72	
Family Practice S 3764		Hearings Concluded	
OMNIBUS PHS Ammendments S 3716		Committee Approved 12/10/71	
Exempt Groups Lobbying HR 13720, 53063	Hearings Concluded		

Status of Current Legislation of Interest

ISSUE	HOUSE	SENATE	OTHER ACTION
Multiple Sclerosis HR 15475	Passed 8/1/72		
Sudden Infant Death Syndrome SJRES 206		Committee Approved 6/2/72	
Communicable Disease Control HR 14455 S 3442	Passed 7/18/72	Passed 6/7/72	Conference Agreement Reached
Ethics of Research SJRES 75		Passed 12/2/71	
Advisory Committee HR 4383 S 3529	Passed 5/9/72	Hearings Concluded	Executive Order 11671 6/5/72
Public Health S 3441		Committee Approved 8/10/72	
National Health Service Corps S 3858		Committee Approved 8/10/72	

DEMOCRATIC +

STATEMENT BEFORE THE REPUBLICAN PLATFORM COMMITTEE

Mr. Chairman and Members of the Platform Committee:

I am Dr. Charles C. Sprague, Dean, University of Texas, Southwestern Medical School at Dallas and Chairman-Elect of the Association of American Medical Colleges. I appear here today as a spokesman for the AAMC.

The AAMC represents all of the 108 medical schools in the United States, approximately 400 of the nation's largest and best known teaching hospitals, and thousand of medical teachers and scientists. These schools, hospitals and doctors produce all of the physicians trained in the United States and almost all of the medical specialists. They are doing a great majority of the medical research and in their work with patients and hospitals are providing a very significant amount of care of seriously ill patients in this country, especially in the large cities and for the indigent population.

Unfortunately, this great country of ours has no national health policy. Our people, although citizens of the wealthiest and most powerful country, do not receive the best health care in the world. Our number one national concern must be the improving of the health of all of our people. The Association is anxious to work with this Committee in an attempt to solve these complex and pressing problems.

Testimony of Dr. Charles C. Sprague, Dean, University of Texas, Southwestern Medical School at Dallas and Chairman-Elect of AAMC before Republican Resolutions "Platform Committee", Eden Roc Hotel, Miami Beach, Florida, August 16, 1972.

It seems to us that the first priority is to provide a single, authoritative point of responsibility for health policy within the federal structure. The scope and magnitude of HEW responsibility for civilian health programs seems to argue compellingly for locating the overall leadership of federal health activities in the Department of Health, Education and Welfare. At the same time, we have become convinced that the present HEW organization is no match for the job of providing the vigorous national leadership that we need for the evolution of sound federal programs in the health field.

The Association feels that a new organizational framework is needed. Some have suggested establishment of a high-level Health Council that would report directly to the President. Others have suggested establishment of the position of Under Secretary of Health. The President's current reorganization proposal would submerge federal health activities in a new Department of Human Resources. The Association feels that the visibility of federal health activities needs to be increased. The Association feels that federal health administrators must be provided with an agency that is manageable. The Association is convinced that the federal role in health is important enough to make the head of the federal health establishment a member of the President's Cabinet. The President is entitled to have a full-time Secretary of Health to whom he can go for advice. And the federal health establishment is entitled to have a full-time Secretary of Health who can be heard in the White House over the clamor of the Office of Management and Budget.

The Association urges legislation which would establish a separate, Cabinet-level Department of Health.

There is an urgent need to make available proper and comprehensive health care at a reasonable rate to all Americans. There is much talk in the

Congress and elsewhere of the development of a national health insurance plan. The Association supports the development of a system of national health insurance which can remove the financial barriers to adequate health care and health maintenance in this country.

We believe health insurance must be compulsory to be really effective and that such a plan should be a combination of private and public insurance. It seems to us that we have in the private insurance industry, both non-profit and profit, resources which should be used, not cast aside. We realize, too, that if and when coverage is compulsory, there must be extensive national standards to insure that the public is safeguarded. This legislation should include more than just the financial aspects. It must be concerned with standards of benefits, claims, and reimbursements and assure fairness in the delivery of benefits through a variety of mechanisms, including a comprehensive prepaid system and the conventional fee-for-service mechanism. Every citizen should be assured of a means for receiving health care. We can no longer rely on the present system. We must evolve a system which assures that every citizen or family will have a simple, understandable place to turn for continuing family and minor medical care. In a few instances this could continue to be the individual family doctor, but strong support should be given to the development of small clinics or primary care centers where groups of doctors can more effectively carry out this primary medical care function. These small groups of individual doctors must, in turn, have full unrestricted access for their patients to an institutional system of hospitals of varying sizes and complexity, long-term care hospitals, and nursing homes.

Much consideration should be given to the establishment of a prepaid group practice to provide care in the rural areas of our country and in the

inner cities. There is an urgent need in these areas for a comprehensive health plan which can be provided by prepaid group practice and which in many cases could be affiliated with the academic medical centers. Unfortunately, many citizens of the inner city and rural America receive little or no preventive medicine--not even prenatal care. Most of our citizens receive medical attention only after they have become ill. Many illnesses can be prevented if the patient has access to proper preventive medicine practices.

Any prepaid practice should be made available with full services on a full-time basis to the subscriber of the plan. There will have to be a mechanism by which the patient can easily transfer from one prepaid group to another without suffering financial loss or loss of services. There must be provisions to accommodate those individuals who are high risk clients.

We also urge this Committee to support the continued development of Regional Medical Programs and the Comprehensive Health Planning Programs of the country. A clear resolution of the respective roles of these two programs is essential to the full achievement of the nation's health objectives.

The medical schools of the country not only will supply the physicians to meet these challenges but also in many cases will help in the training of other health professionals who support the role of the physician. Medical education is a lengthy and very expensive process. The first session of the 92nd Congress passed landmark legislation that recognized for the first time the basic fact that the training of a physician is truly a national reponsibility. The Congress is now providing for broad base support of medical education. In the past, much of the federal money that went to academic medical centers was in the form of special grants for a specific purpose, leaving little or no opportunity for the academic medical center to have the freedom which this

wrong with the present system. Health will be improved by utilizing additional people in the caring process -- such as the physician assistant, the nurse practicioner, the health promoter, the behavioral scientist and the family counselor -- to help families deal with the problems of living in this increasingly complex and demanding society. There must be a better articulation among primary, secondary and tertiary care, through some regionalization approach, to make maximum use of what will always be inadequate resources for optimal health care.

Although the United States ranks high among developed nations of the world in the number of physicians and other health professionals to the population, it is moving to increase the number of health professionals to make certain that they do not become a limiting factor. In accomplishing this goal, the federal government and the nation's medical schools are working together. Last year, for example, with the guidance of this subcommittee, Congress enacted major new legislation, the Comprehensive Health Manpower Training Act of 1971, to aid medical schools to expand enrollments and thus increase the output of M.D.s. Over the past 10 years, the number of U.S. medical schools has increased from 87 to 108 (with two additional U.S. schools scheduled to become operational this fall) and the size of the graduating class has increased from 8,772 to nearly 11,000.

Beyond the overall shortage there are serious problems associated with the geographic and specialty maldistribution of physicians. In terms of geographic maldistribution, for instance, the United States has a national average of one physician for every 680 persons, although there is nearly a threefold variation among the states. California, the state most plentifully supplied with physicians, has one to every 625 persons; Alaska, the least fortunate, has only one to every 1,600 persons. In terms of specialty maldistribution, there appears to be an excessive number in some specialties at the

I would like to urge you to make a strong commitment toward the encouragement and support of biomedical research. Nearly all of the biomedical research which is done in this country is performed at the academic medical centers. Basic research is laborious and expensive. However, it is vital if we are to understand the living process of man, the nature of the diseases which plague him, and the development of more effective ways to prevent, diagnose, and treat disease. Many of the dread diseases of 20 years ago are no longer stalking mankind. However, we must not rest on past success. New problems are constantly appearing and many old diseases are still with us. Our only hope for progress against disease is a strong biomedical research program which would initiate both investigator research projects and categorical research. As I have mentioned, research is expensive but simply treating the effects of disease is far more expensive and much more devastating.

Sophisticated research has brought us a greater understanding of the nature of the life process. Now is the time with this greater knowledge that an all out attack upon disease can be made. This is not the time to handicap the research scientists due to the lack of financial support. I urge that a new look be taken by the Federal Government at the rewards which can be achieved through biomedical research and that the Republican Party make a strong and earnest dedication to increase aid in this area, but not at the expense of other areas in health care delivery and medical education.

We are also concerned about the availability of an adequate supply of research scientists to carry out programs such as those called for in the recently enacted National Cancer Act of 1971. The failure to adequately fund research programs has seriously compromised the ability of the academic medical centers to train enough scientists to respond to the mandates of the

people which are reflected by the legislation enacted by the Congress.

Finally, Mr. Chairman, I am proud to report that many of the students who are currently enrolled in our medical schools come from a variety of socio-economic backgrounds. Many of these students are dependent upon scholarships to see them through their education. It is our belief, as I am sure it is yours, that no talented person should be denied the opportunity to seek a medical education because of the lack of funds. Many of the schools which have traditionally offered scholarships to worthy students from their endowment funds have been forced to discontinue this practice. Due to the financial distress experienced by many of the medical schools, it was necessary for them to use the endowment funds simply to keep the doors of their institutions open. A medical student is unique in that he does not have the opportunity to work his way through school. The student is required to spend much time in the classrooms, clinics, and the hospitals in order to master the increasingly complex study of medicine. The medical student is also unique in that he does not have a summer vacation which would afford the student the time to earn money that can be applied to his education. I strongly urge this committee to consider retaining and increasing the amount of federal funds which may be used to provide scholarships for medical students.

I appreciate this opportunity to present the AAMC views on the health of our nation. I will be more than happy to answer any questions you or any member of the committee might have, Mr. Chairman.

Thank you.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON LEGISLATION TO SUPPORT TRAINING IN FAMILY MEDICINE, TO PROVIDE ASSISTANCE FOR MEDICAL LIBRARIES AND TO SUPPORT TRAINING OF PUBLIC HEALTH PERSONNEL*

Mr. Chairman and members of the subcommittee:

The Association welcomes this opportunity to testify in these hearings on a variety of legislative proposals to support training in family medicine, to provide assistance for medical libraries and to support the training of public health personnel.

Formed in 1876 to work for reforms in medical colleges, the Association has broadened its activities over the years, so that today it represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 108 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 52 learned academic societies whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all of the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It

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* Presented by John A.D. Cooper, M.D., President of the Association of American Medical Colleges, before the Subcommittee on Health of the Senate Labor and Public Welfare Committee, July 27, 1972.

is concerned with the delivery of health care, directly through the facilities of teaching hospitals, and indirectly through the development of improved community health services. It is concerned with innovation and experimentation in all of these fields. The Association and its membership thus have a deep and direct interest in each of the various legislative proposals under consideration in these hearings.

Each of these proposals is important and deserves comment in some detail. This statement presents the Association's views on the proposals in the following order: training in family medicine, assistance for medical libraries, and training of public health personnel.

Training in Family Medicine

The legislation (S 3764) introduced by Subcommittee Chairman Kennedy and others to provide for increased training in the field of family medicine reflects the nation's deep, current concern with the way in which health care is delivered in this country. The legislation proposes to extend the Family Practice of Medicine Act of 1970 for one year, to June 30, 1974, with an authorized appropriation of $100 million for that fiscal year. The Association is aware of the unresolved dispute concerning the legal status of the Family Practice of Medicine Act of 1970. However, this is not in the Association's field of expertise.

Senator Kennedy's current legislative proposal does raise issues which are in the Association's field of expertise, and this statement will deal with these issues. The legislation proposes grants for professional and technical training in the field of family medicine. The programs grew out of concerns about deficiencies in the availability of primary health care in our nation. S 3764 proposes to remedy the situation by giving

Congressional emphasis and special financial support to the field of family medicine.

The Association feels that this legislation at present is excessively narrow in scope but is certain it could be made more effective in dealing with the issues. The Association recognizes that the present system is not responding adequately to society's rising expectations for health care. As the Subcommittee is well aware, through its hearings and studies, the problem is complex and has many components. Society is calling for a simple, understandable way to gain access to the health care system and a reasonable and equitable way for covering the costs of care delivered. The American people are seeking an alternative to the counterproductive and confusing fragmentation and compartmentalization of health care services. They want the physician to be concerned with more than their organic disease, but they want him also to apply the benefits of advancing knowledge in medicine and the biomedical sciences to the prevention, diagnosis and treatment of their illnesses. By their patterns of seeking health care, they have clearly indicated that they do not wish a return to the style of the physician of the early 1900s, whose major contributions to health care were the laying-on of hands and reassurance. People want competent, adequately trained, scientifically based, primary care physicians. They also want more sophisticated and specialized secondary and tertiary care when it is necessary.

The institutional form for the delivery of health care is under evolutionary development in the United States. It seems clear that the solo practicioner, carrying his little black bag and being all things to all people, will not be the method for bringing primary care to most of the population. The rapidly increasing number of group practices suggests that

they will be a part of the new arrangements. Group practice appears to be acceptable to both the consumer and the provider. Physicians making up the group either can be family practicioners, with each physician expected to have many skills and to minister to many patients of all ages, or can be a combination of generalist internists, generalist pediatricians, and obstetricians-gynecologists, sharing their respective skills in ministering to patients. As the size of the group increases, more highly trained specialists can be added to provide "one-stop medical care." To stimulate and support the development of both options, the Association strongly urges that support be provided to train both kinds of primary care physicians. At present, the only ongoing Federal support for the graduate education and training of internists, pediatricians and obstetrician-gynecologists is in the subspecialty areas and for research and teaching. These programs need to be continued to meet the total needs of the system and to provide the faculty required to expand the output of physicians from our education and training programs. In addition, special funds are needed to support graduate training programs for "generalist specialists" in continuing, comprehensive care. Support also is needed to provide opportunities for undergraduate medical students and house staff to learn and practice ambulatory as well as crisis-oriented inpatient medicine. These things could be accomplished by enacting legislation to support all programs producing primary care physicians, rather than limiting the support to one kind of primary care physician, the family practicioner.

There must be a more intelligent and efficient employment of the nation's 3.7 million health personnel, if adequate health care services are to be achieved. By improving the division of labor and by lessening the burden on the physician, a creditable solution can be achieved for much of what is

wrong with the present system. Health will be improved by utilizing additional people in the caring process -- such as the physician assistant, the nurse practicioner, the health promoter, the behavioral scientist and the family counselor -- to help families deal with the problems of living in this increasingly complex and demanding society. There must be a better articulation among primary, secondary and tertiary care, through some regionalization approach, to make maximum use of what will always be inadequate resources for optimal health care.

Although the United States ranks high among developed nations of the world in the number of physicians and other health professionals to the population, it is moving to increase the number of health professionals to make certain that they do not become a limiting factor. In accomplishing this goal, the federal government and the nation's medical schools are working together. Last year, for example, with the guidance of this subcommittee, Congress enacted major new legislation, the Comprehensive Health Manpower Training Act of 1971, to aid medical schools to expand enrollments and thus increase the output of M.D.s. Over the past 10 years, the number of U.S. medical schools has increased from 87 to 108 (with two additional U.S. schools scheduled to become operational this fall) and the size of the graduating class has increased from 8,772 to nearly 11,000.

Beyond the overall shortage there are serious problems associated with the geographic and specialty maldistribution of physicians. In terms of geographic maldistribution, for instance, the United States has a national average of one physician for every 680 persons, although there is nearly a threefold variation among the states. California, the state most plentifully supplied with physicians, has one to every 625 persons; Alaska, the least fortunate, has only one to every 1,600 persons. In terms of specialty maldistribution, there appears to be an excessive number in some specialties at the

same time that there are serious shortages in others.

Attempting to deal with the problems of geographic maldistribution in a free society has proven extremely difficult. It simply is not possible for the federal government to regulate the location of a physician's practice, except through voluntary agreements such as participation in the National Health Service Corps. Health professionals, and others, tend to gravitate toward areas of the country which provide opportunities for intellectual development, professional growth and social and cultural enrichment. These factors militate against the location of physicians in urban ghetto and rural areas.

The problem of distribution of specialty training opportunities will be an important one for a newly established consortium of voluntary organizations concerned with the continuum of medical education. The new group is composed of representatives from the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the Committee on Medical Specialty Societies, the American Hospital Association, the general public and the federal government. This new group is called the Liaison Committee on Graduate Medical Education. Through a coordinating council and liaison committees on undergraduate and graduate medical education, it has the potential to develop policy and to modify the specialty distribution of physicians.

The inability to pay for medical services continues to be a major barrier to adequate health care for many people. Congress has made an important beginning in the confrontation of this problem through the enactment of the programs of Medicare and Medicaid, to help meet the costs of medical care for low-income and elderly Americans. Only through some form of national health insurance, such as now being considered by the Congress, does it seem

possible to provide access to adequate health care for all Americans, regardless of income or age.

This review should help to underscore the point that the problems associated with inadequate primary health care cannot be considered in isolation from the broader problems affecting the whole health care system. While the overall problems are yet to be resolved, the Congress has enacted legislation that is directed toward overcoming inadequate primary health care. It is already producing results.

The 1971 health professions education assistance legislation provides authority for special project grants for health professions schools to improve, establish or expand programs in family medicine training. The legislation also provides authority for traineeships for students to serve under family practice preceptors during part of their medical training. In addition, the legislation provides authority for training grants in family medicine to hospitals for their graduate clinical training programs. These grants encourage the development and improvement of such programs as well as provide financial assistance to resident graduate students planning careers in the field of family medicine.

The combined effect of a clearly expressed Congressional concern and this set of legislative authorities is impressive.

On the undergraduate level, the Department of Health, Education and Welfare's Bureau of Health Manpower Education has received 45 applications from schools for special project grants in family medicine. Although awards have not yet been made, the applications are diverse in scope and creative in approach, as schools attempt to meet the problem in many ways. For fiscal year 1972, $53 million was appropriated for special projects, including training programs in family medicine. The Administration has requested the same amount in fiscal year 1973, although Congressional action seems certain to increase the Administration's request.

Across the nation, 31 medical schools have established departments of family medicine, and an additional 30 schools have established divisions of family medicine. This means that 61 schools offer family medicine programs which include units of ambulatory care and other primary health care training. Altogether, 94 schools now offer some required or elective experience in family medicine. Some of the experience obviously is offered in schools which have neither departments nor divisions of family medicine, where it is offered as part of other training. Most importantly, even in schools which have established special family medicine organizational units, a great deal of the experience is provided in other departments and divisions of training. And, finally, 15 schools offer early entrance into a career of family practice. This option for early specialization provides opportunity for a broad, in-depth training experience. (Tables are attached at the end of this statement which show which schools are engaged in these activities.)

On the graduate level, 91 applications from hospitals for training grants in family medicine have been received by the Bureau of Health Manpower Education. Of these, 61 have been approved and 52 funded. Congress appropriated $5 million for this program, and of that, 21 percent of the funding was specifically directed for training stipends. The entire grant was spent on training stipends in a few cases. The number of residents in these approved training programs is 738; the number of residents receiving stipends is 150.

From across the country, the records of the National Internship and Residency Matching Program, a clearinghouse designed to help graduating medical students obtain a postgraduate appointment at the hospital of their choice and to help the hospital obtain the graduates of its choice, provide specific data demonstrating the increase in training in family medicine. From 1970 to 1972, teaching hospitals under the Matching Plan have increased the number of training programs in family medicine from 21 to 67; the positions offered

in the programs have increased from 111 to 471; the number of residents who applied and were matched in these programs increased from 42 to 304, a jump of 620 percent. In 1970, 42 residents filled 111 offered positions, filling 39 percent of the available positions; in 1972, 304 residents filled 471 offered positions, filling 65 percent of the available positions. While in 1970, only five out of 21 resident training programs in family medicine were completely filled (24 percent), 25 out of 67 programs (37 percent) were completely filled in 1972.

It seems to the Association that this is an impressive record of achievement. It marks a high degree of cooperation among the federal government, medical schools and teaching hospitals. What is disappointing to the Association is the apparent absence of equal Congressional concern for the broad spectrum of primary health care. The schools clearly perceive the need for training increased numbers of physicians in all the fields of primary health care, but the cost of such increased training is far beyond the financial resources of the schools. Additional financial assistance is essential. The record of the schools and teaching hospitals, when special assistance was provided for training in family medicine, indicates that major gains can be made with sufficient financing.

The Association, therefore, strongly urges equal Congressional consideration of the other important fields associated with primary health care. Specifically, the Association recommends that positive use be made of the existing authority in the Comprehensive Health Manpower Training Act for support of graduate medical education. This authority presently provides a $3,000-per-person annual capitation grant for graduate training in primary care and in other health care areas in which the Secretary determines there is a shortage of personnel. Despite a $7.5 million authorized appropriation for fiscal 1973,

the first year of the program, no money has been requested or appropriated for this program. Continuing and substantial federal support for graduate medical training programs carefully administered on a national level would provide the means to deal with urgent problems of specialty training in important areas of national need. In fact, such support would be a useful complement -- at the graduate training level -- to the support for undergraduate training approved by Congress last year in the health professions education assistance legislation.

This broader support for graduate medical education and training, which the Association is proposing, would permit positive action in all fields of health care, including primary care. It should also be flexible enough to permit creative new approaches and solutions and should avoid unnecessary dictation of prior terms and conditions. Externally imposed requirements affecting the internal management of a school or hospital -- however well-intentioned -- are likely in operation to prove excessively rigid and, perhaps, even educationally unsound. The organizational environment of each school and hospital is different, and it seems true that the very best programs are the ones that are developed naturally from the organizational environment of the institution in response to a perceived need.

What the medical educational community urgently needs is substantial and stable support for innovation in medical education aimed at increasing its relevance to the development of a system of medical care services characterized by comprehensiveness, continuity, competence, humaneness and family orientation. Such a system clearly demands an increased number of primary care physicians. With this type of flexible support, medical education can continue its attempt to make a maximum contribution to the public need.

Assistance for Medical Libraries

The nation's medical libraries serve as points at which the health professional and the student intersect the scholarly record. Because new knowledge, new and broader societal demands and new technologies are accumulating so rapidly, the student who leaves the educational environment without an appreciation for both the traditional and the new methods for remaining up to date will always have difficulty. A library will almost certainly serve as the principal instrument by which he can stay up to date. Therefore, he must become familiar with its use while he is in an educational setting. At the same time, it is becoming increasingly imperative that the medical library take on a new identity to respond adequately to the changing demands that are being placed upon it.

To provide programs for assistance to medical libraries Congress enacted the Medical Library Assistance Act of 1965. In 1970, the Act was extended for three years, through June 30, 1973. Legislation introduced by Subcommittee Chairman Kennedy and others, S 3752, extends these programs for assistance to

medical libraries through June 30, 1974. The programs provide assistance for construction of facilities, training in medical library sciences, special scientific projects, research and development in medical library science, establishment, expansion and improvement of basic resources of medical libraries, establishment of regional medical libraries, and financial support of biomedical scientific publications.

Because a medical library is deeply involved with each of the three principal functions of an academic health center, research, education and patient care, the Association of American Medical Colleges has a vital interest in these programs of assistance. The dependence of biomedical research on access to the relevant literature is obvious, and each research project results in the publication of new literature. The medical library has a role in both providing access to the existing literature and in organizing access to the new literature. In medical education, the medical library plays a vitally important role as a learning center which touches every facet of the student's educational career. In patient care, the medical library provides physicians with access to the published literature so they may keep abreast of new developments in the study and care of patients.

The most serious challenge facing medical libraries today is the explosive increase of scientific information and the requirement to keep responsible practicioners abreast of new knowledge. To meet this challenge, libraries must do more than simply extend their existing functions. One of the most widely discussed new approaches is the multimedia package, a combination of visual and auditory stimuli coupled with an active role for the learner. The multimedia package incorporates a number of new technologies, some of which are still either underdeveloped or in rudimentary phases. Despite these problems, libraries should be encouraged to rely on these new technologies as the libraries attempt

to respond to the new pressures on medical education. These pressures include more students, different students, more knowledge, different knowledge, changing social structure, different methods of financing, heightened expectations, and time compression. The Association is convinced that medical libraries must begin now a very active period of research into the most feasible modalities for disseminating the scholarly record to the scientist and the student. The medical librarian must be willing to accept an educational role that is much beyond anything he has been asked to accept up to this time. The medical library must adopt an entirely new philosophy in the area of service, if the information gap is to be closed.

One way in which the medical libraries of the nation already are attempting to deal with the information explosion is through the biomedical communication network operated by the Lister Hill National Center for Biomedical Communications. The network includes a library network, among its other elements, which is already in being, and through which the National Library of Medicine is joined to 11 regional libraries and they in turn are joined to some 500 or 600 local libraries throughout the nation. Because of the importance of this network to biomedical education, the Association of American Medical Colleges and the National Library of Medicine conducted a study of what messages should be communicated by the network and who should be responsible for determining the content of the messages. The report on that study, which contained more than 50 specific recommendations, was printed in the July 1971 issue of the Journal of Medical Education and was entitled, "Educational Technology for Medicine: Roles for the Lister Hill Center."

For the nation's medical libraries to meet the challenge of the information explosion and to take the fullest advantage such advances as the national biomedical communications network, the libraries must expand their facilities, train increasing numbers of new kinds of personnel, vigorously pursue new

research leads in library science, and develop and secure a sound financial base. Each of these requirements is costly, carrying a price tag that is far larger than the libraries themselves can afford. Because these libraries serve the academic health centers of the country, which Congress has acknowledged as national resources, federal financial assistance in meeting these requirements is appropriate. This kind of assistance is provided through the Medical Libraries Act of 1972. It is unfortunate, however, that the legislation provides for only a one-year extension of federal assistance programs for medical libraries. Such a short time-period does not encourage the best planning. To provide a source of continuing, stable federal financial assistance for medical libraries, the Association strongly recommends a multi-year extension of these assistance programs. In the past, Congress has enacted programs of up to five years' assistance. The Association suggests consideration by the subcommittee of such a time period once again.

Training of Public Health Personnel

Professional public health personnel are the "providers" of health services planning, organization, administration and coordination through which scientific knowledge and skill are brought together with material resources to serve the health needs of the people in the aggregate. These teachers, managers and leaders comprise a national talent bank which deals with the total health needs of the nation's rapidly increasing population in this increasingly complex society.

To expand and improve the opportunities for health personnel to undertake graduate or specialized training in public health, Congress enacted the Hill-Rhodes Act of 1958. As currently in effect, the Act provides institutional support through formula and project grants, to help meet the costs of maintaining and expanding educational programs in public health, and student assistance through traineeship grants, to help defray the student's costs of taking such advanced, specialized education. Present legislative authorities for these programs are due to expire on June 30, 1973. Legislation introduced by Subcommittee Chairman Kennedy and others, a bill (S 3441) to extend the traineeship program for professional public health personnel and project grants for graduate training in public health, extends the programs for an additional five years, through June 30, 1978.

The medical schools and academic health centers of the nation are deeply involved in the education and training of public health personnel. For that reason, the Association of American Medical Colleges is gratified at the consideration of S 3441 and urges favorable action by the Health Subcommittee. The Association does not have the knowledge, however, to discuss the legislation in detail. For that purpose, it defers to the Association of Schools of Public Health and asks to be associated with its thoughtful views.

The following is a list of schools with either departments or divisions of Family Medicine. There are 31 schools with departments and 30 schools with divisions, for a total of 61 schools.

Univ. of California-Davis	Department
Howard	Department
Univ. of Florida-Gainesville	Department
Univ. of Florida-Miami	Department
Univ. of South Florida	Department
Univ. of Georgia	Department
Chicago Medical	Department
Loyola-Stritch	Department
Univ. of Southern Illinois	Department
Univ. of Illinois-Abraham Lincoln	Department
Rockford	Department
Rush Medical College	Department
Univ. of Iowa	Department
Univ. of Kansas	Department
Univ. of Kentucky	Department
Univ. of Louisville	Department
Minnesota	Department
Nebraska	Department
Texas Tech (Lubbock)	Department
Galveston	Department
San Antonio	Department
Utah	Department
Medical College of Virginia	Department
Univ. of Washington	Department
SUNY-Stony Brook	Department
SUNY-Downstate	Department
SUNY-Upstate	Department
Univ. of North Carolina	Department
Hahnemann	Department
Penn State	Department
South Carolina	Department
Alabama	Department
Arizona	Division
Arkansas	Division
Loma Linda	Division
UCLA	Division
UCSD	Division
Univ. of California-San Francisco	Division
University of Colorado	Division
Univ. of Connecticut	Division
Peoria	Division
Univ. of Indiana	Division
LSU-New Orleans	Division
Maryland	Division
Harvard	Division
Wayne State	Division

Mississippi	Division
Univ. of Missouri	Division
Creighton	Division
Vermont	Division
Univ. of Virginia	Division
West Virginia	Division
Medical College of Wisconsin	Division
Univ. of Wisconsin	Division
New Mexico	Division
SUNY, Buffalo	Division
Rochester	Division
Oklahoma	Division
Oregon	Division
Jefferson	Division
Baylor	Division

The following is a list of schools which offer either required or elective experience in Family Medicine. A total of 94 schools offer such experience.

Alabama	Louisville
Arizona	Tulane
Arkansas	LSU, New Orleans
Stanford	Maryland
California, San Francisco	Boston U.
U. Wisconsin	Tufts
University of Southern California	Massachusetts
California, San Diego	Wayne State
California, Davis	Michigan
California, Irvine	Michigan State
Colorado	Minnesota, Minneapolis
Yale	Minnesota, Duluth
Connecticut	Mississippi
Georgetown	St. Louis
Howard	Washington University (St. Louis)
Florida	Missouri, Columbia
South Florida	Creighton
Miami	Nebraska
Georgia	Nevada
Emory	Rutgers
Chicago Medical School	Newark
Rush	New Mexico
Southern Illinois	SUNY, Buffalo
Illinois	SUNY, Downstate
Indiana	SUNY, Upstate
Iowa	SUNY, Stony Brook
Kansas	Cornell
Kentucky	Albany
Einstein	NYU
Rochester	Duke
Bowman Gray	University of North Carolina

North Dakota
Ohio State
Oregon
Pennsylvania State
Jefferson
Tennessee
Texas, Galveston
Southwestern
Utah
Medical College of Virginia
Washington, Seattle
UCLA
Medical College of Wisconsin
South Carolina
Peoria
West Virginia

Case Western Reserve
Medical College of Ohio
Medical College of Pennsylvania
Pennsylvania
Temple
Baylor
Texas, Houston
Texas Tech
Vermont
U. Virginia
Hahnemann
San Antonio
Loyola Stritch
Loma Linda
Harvard
Oklahoma

The following is a list of schools which offer early entrance into a career of Family Practice. There are 15 schools which offer such an opportunity.

Stanford
California, San Francisco
California, Davis
California, Irvine
Colorado
Rush
Illinois
Massachusetts

Minnesota, Minneapolis
Minnesota, Duluth
New Mexico
SUNY, Stony Brook
University of North Carolina
Texas, Galveston
Washington, Seattle

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON LEGISLATION TO IMPROVE MEDICAL EMERGENCY TRANSPORTATION AND SERVICES*

Mr. Chairman and members of the subcommittee:

The Association of American Medical Colleges welcomes this opportunity to appear before the subcommittee during its consideration of legislation to improve the transportation and services available in medical emergencies.

Formed in 1876 to work for reforms in medical colleges, the Association has broadened its activities over the years, so that today it represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 108 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 52 learned academic societies whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It is concerned with the delivery of health care, directly through the facilities of teaching hospitals, and indirectly through the development of improved community health services. It is concerned with innovation and experimentation

*Presented by John A.D. Cooper, M.D., President of the Association of American Medical Colleges, before the Public Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee, June 14, 1972.

in all of these fields. The Association and its membership thus have a deep and direct involvement in the legislation this subcommittee is now reviewing.

The Need for Action

Today more Americans require hospitalization for accidents than for any other diseases except cancer and heart disease. Yet as a nation we spend less than one percent of the amount spent on cancer or heart disease in alleviating this problem. Accidental death and disability are truly, as described by the National Academy of Sciences, "the neglected disease of modern society."

Last year, more than 115,000 Americans lost their lives in accidents. Four hundred thousand more were permanently disabled and 10 million more temporarily disabled. The loss to the national economy from accidents last year has been estimated to be more than $28 billion. These are sad and staggering figures. And they are made especially so by the fact that this toll could be reduced greatly through the application of already available knowledge in upgrading our emergency medical services. An improvement of only ten percent in emergency care would save 15,000 lives and more than three million hospitalizations, and would return $3 billion to the economy, it has been estimated.

What is needed are systems which bring together better transportation services; communications which would tie hospitals, transportation facilities and emergency organizations into rapid response systems; and emergency medical centers with specially trained doctors and nurses. Such systems already exist in some other countries, notably the Soviet Union, and are under development in parts of this country, in the state

of Maryland, for example. A number of federal agencies are cooperating in the Military Assistance to Safety and Traffic (MAST) program, to explore the feasibility of utilizing military helicopters and service paramedical personnel in responding to civilian medical emergencies, particularly to highway accidents.

More clearly needs to be done. And this has been recognized by President Nixon in a number of important messages to this session of Congress.

In his January 20 State of the Union Message, the President said: "...I am directing the Department of Health, Education and Welfare to develop new ways of organizing emergency medical services and of providing care to accident victims. By improving communication, transportation and the training of emergency personnel, we can save many thousands of lives which would otherwise be lost to accidents and sudden death."

In his March 2 health message, the President said: "By using new technologies to improve emergency care systems and by using more and better trained people to run those systems, we can save the lives of many heart attack victims and many victims of auto accidents every year. The loss to the nation represented by those unnecessary deaths cannot be calculated."

In his March 17 message on science and technology, the President said: "Since the beginning of this Administration, I have felt that we should be doing more to focus our scientific and technological resources on the problems of the environment, health, energy, transportation and other pressing domestic concerns....I have identified a number of areas where new efforts are most likely to produce significant

progress and help us meet pressing domestic needs. They include.... providing more efficient and effective health care, including better emergency health care systems."

To meet these recognized needs, the President has allocated $8 million in fiscal 1972 to develop model systems and training programs and has proposed that $15 million be invested for additional demonstrations in fiscal 1973.

House Legislation

Two principal House bills have been introduced to improve the transportation and services available in medical emergencies.

--HR 12563, the Medical Emergency Transportation and Service Act, was introduced by Subcommittee Chairman Rogers and others to authorize the establishment of medical emergency transportation and service programs. The bill adds a new part K to title III of the Public Health Service Act to authorize grants and contracts for medical emergency transportation and treatment projects; to authorize operating grants for approved medical emergency transportation and treatment programs; and to upgrade the trauma research program of the National Institute of General Medical Sciences by establishing a National Research Program in Trauma and Emergency Medical Care. The bill provides for three-year, open-ended authorizations.

--HR 12787, the Emergency Medical Services Act, was introduced by Representative Mollohan of West Virginia and Representative Robison of New York, to establish an Emergency Medical Services Administration within the Department of Health, Education and

Welfare and to assist communities in providing professional emergency medical care. The bill upgrades and renames the present Emergency Health Services Division in the Health Services and Mental Health Administration and centralizes federal functions relating to the improvement of emergency medical transportation in the newly created Emergency Medical Services Administration in DHEW. The new agency is to establish standards for operation of ambulance and related services; to provide financial assistance for the operation of local ambulance services and for the initial purchase of ambulance equipment; and to conduct studies and research projects related to emergency medical care and services. The bill authorizes appropriations of $555 million over three years, starting with $150 million in fiscal 1973.

Association Comments

The Association of American Medical Colleges agrees that there is a clearly demonstrated need for an increased federal role in research on and improvement of emergency medical care and services. It is only necessary to consider some figures on victims of heart attacks -- a disease which Congress and the President have singled out this year for a major federal initiative -- to understand the need for upgraded emergency medical services. Of the estimated 600,000 Americans who die each year because of coronary heart disease, nearly seventy percent die outside of the hospital. The heavy national investment in hospital-based, sophisticated and expensive medical techniques and equipment is worthless if the patient isn't brought to the hospital in time.

The Association acknowledges and appreciates that both the House and the Senate have included federal support for emergency medical services in their legislation to advance the national attack against heart disease.

In considering the two principal legislative proposals before the subcommittee, the Association has reached certain conclusions.

It feels that Representative Mollohan's bill, the Emergency Medical Services Act, contains many useful proposals centered, however, almost exclusively around ambulance service. Other aspects of emergency medical care and service do not appear to be covered by this legislation. Emergency medical care really is a complex set of related activities dealing with all forms of transportation, communication networks, hospital emergency departments and intensive care units, and health care personnel. Thus, the Association feels that this bill is too limited in terms of the problem to be dealt with.

The proposal in Representative Mollohan's legislation to consolidate federal emergency medical transportation activities in a single DHEW agency appears to have considerable merit, although the Association really lacks sufficient knowledge in the field of government organization to comment in any but the most general terms. Participation in the federal MAST program by three government agencies, the Departments of Defense; Health, Education and Welfare; and Transportation, suggests at least the possibility of fragmented authority and responsibility. And as a general rule, it always seems desirable to avoid such fragmentation whenever possible.

Representative Rogers' bill, the Medical Emergency Transportation and Service Act, would provide a considerably broader and, the Associa-

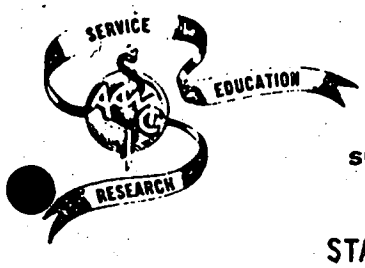
tion believes, a more effective framework to deal with the problem of emergency medical care. Grants and contracts are authorized for medical emergency communications and transportation systems and for the training of medical emergency transportation service personnel. Operating support is available to help meet the cost of ongoing medical emergency transportation and treatment programs. And additional grants and contracts are authorized for programs to train health care personnel in medical emergency techniques and methods. Perhaps most importantly, the bill requires development of a plan for the implementation of medical emergency transportation and treatment programs.

As recommended by the National Academy of Sciences, the Rogers bill provides for increased federal research in trauma. The bill authorizes the HEW Secretary to make grants and contracts to carry out basic and clinical research in shock and trauma under a National Research Program in Trauma and Emergency Medical Care, which the bill establishes in the National Institute of General Medical Sciences. The NIGMS currently supports some ten trauma centers scattered throughout the country at various major medical schools. The total support is slightly under $3 million.

The Association feels it is important to emphasize in any discussion of emergency care that the nature of the care provided in hospital emergency departments is undergoing significant and rapid changes. The emergency department is becoming for many Americans the point of access to the medical care system. The dividing line between ambulatory care and emergency care is blurring. Many emergency department patients have problems that could have been handled in the office of a good primary physician, and, perhaps, soon will be handled through

a health maintenance organization. In some emergency departments now as few as one out of every ten patients has trauma. As a result, the conception that there is a relatively finite body of medical and scientific knowledge which would prepare a physician to provide emergency medical care seems to be a considerable oversimplification. Most undergraduate medical students now are provided with considerable experience in emergency departments, and most good residency programs also provide emergency department experience.

While it is important to emphasize the need for improved emergency care, and it is tempting to consider training emergency medical specialists, the Association must strongly caution against meeting the need with such an approach. The nature of emergency care is changing rapidly. The ambulatory care patients in some cases nearly threaten to drive the real emergency cases out of the emergency department. And efficient, effective medical care of heart attack or traffic accident victims requires a smooth integration of the emergency department, the intensive care unit, and other elements and personnel of the hospital.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON LEGISLATION TO IMPROVE THE HEALTH CARE DELIVERY SYSTEM*

Mr. Chairman and members of the subcommittee:

The Association of American Medical Colleges welcomes this opportunity to appear before the subcommittee during its consideration of legislation to improve the health care delivery system by, among other things, encouraging the establishment of health maintenance organizations.

Formed in 1876 to work for reforms in medical colleges, the Association has broadened its activities over the years, so that today it represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 108 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 52 learned academic societies whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all of the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It is concerned with the delivery of health care, directly through the facilities of teaching hospitals, and indirectly through the development of improved community health services. It is concerned with innovation and experimentation

*Presented by Robert M. Heyssel, M.D., Associate Dean for Health Care Programs, The Johns Hopkins University School of Medicine, Baltimore, Maryland, and Chairman of the Health Services Advisory Committee of the Association of American Medical Colleges, before the Health Subcommittee of the Senate Labor and Public Welfare Committee, May 18, 1972.

in all of these fields. The Association and its membership thus have a deep and direct involvement in the legislation this subcommittee is now reviewing.

The Need for Action

The number and variety of the currently pending legislative proposals directed toward new modes of health care delivery provide ample evidence of the broad, grass-roots agreement on the need for urgent national action to improve a health care system which is not meeting society's expectations.

Such wide-spread agreement is encouraging. But the Association is constrained to emphasize a basic point. The ultimate solution to the problem of more adequate health care will not be achieved through the enactment of yet another separate, categorical program of federal assistance. The ultimate solution requires the development of a clear, coherent, and comprehensive national health policy supported by stable financing. This policy should set forth the objectives to be sought, delineate the public and private roles, and provide the program strategy that will assure the availability of effective health services to all the people of the nation.

Without a coherent and comprehensive program strategy and a clear assignment of responsibility, neither a new set of national goals nor new financing mechanisms, alone, will solve the widely acknowledged problems of uneven distribution of health care personnel and resources, both in terms of geographic location and in terms of medical specialty; the ineffective utilization of physicians, nurses and other health personnel; the overemphasis on treatment of sickness rather than on maintenance of health; and the counterproductive fragmentation of health care, symptomized in separate and competing services for veterans, the military, the elderly, the poor, the blind and so on.

A direct confrontation of these problems in implementing a national health policy is central to their resolution.

There are a number of factors which will bear on achieving the goals. Competing economic pressures may limit the rate at which a full and comprehensive health care program can be instituted. There are also finite limits to the rate at which health personnel, facilities and other health resources can be made available and organized to provide comprehensive care.

Role of the Academic Health Center

The Association of American Medical Colleges believes the nation's academic health centers can make a significant contribution in the development of more effective health care services, such as health maintenance organizations. Engagement with the problems of medical care and health services in the community setting has become an essential part of the education of health personnel. By virtue of their special expertise, investigative capability and access to other university resources, academic health centers can contribute innovative approaches and concepts. The teaching hospitals and clinics of an academic health center are vital resources and can be made to serve as an integral component of the framework of community or regional health services. The role of the academic health center in HMO development will be a varied one -- educator, sponsor, catalyst, affiliate for tertiary services -- depending on the institution and the region involved. What is certain for the academic health center

is that it will have a role and that the role will be an important one.

One of the most important aspects of the role of the academic health center in HMO development will be in providing the educational framework for the production of personnel for HMOs and other primary care service. If the HMO, with its emphasis on comprehensive health and preventive care, services to defined populations and prospective budgeting of costs through prepayment, is to emerge as one of the prominent organizations for delivery of health care in the future, it is essential that HMOs become one of the settings in which medical students, interns and residents, along with members of other health professions and occupations receive a significant part of their clinical training. Full participation of the academic health center in HMO development is important in influencing the attitude, interest and involvement of physicians in this form of health service delivery.

The concern of academic health centers in improved health care delivery has already been demonstrated by their participation in a variety of innovative programs, particularly those developed by the Office of Economic Opportunity, those supported under the Comprehensive Health Planning Act and the full range of comprehensive child care programs of the Children's Bureau. Medical schools and teaching hospitals now participate in over half the comprehensive health services projects of OEO. The emphasis in these programs has been upon organized arrangements for providing comprehensive medical care and services to defined populations. An additional feature has been expanding interest in experiments with capitation payments through title XIX and employee health benefit programs.

Academic health centers provide ambulatory and acute hospital services to all segments of the population including the poor and near-poor. The health maintenance organization concept affords an approach that will permit

the academic health center to continue its concern for serving all socio-economic groups in one system of care, and to do so in a manner that is acceptable and responsive to the health care needs of patients and has potential for positive impact upon their health status. HMO development should not be concentrated in urban areas only. There are large rural and migrant populations which have only limited access to primary health care. Academic health centers located in these areas have opportunities to participate in rural HMOs that could provide comprehensive health service, help redistribute health manpower and resources, and could create continuity among primary, secondary and tertiary care.

A recent Association survey shows that a number of academic health centers are already active in HMO development. Among the most outstanding of the new health care programs developed to provide prepaid health care to defined populations are three sponsored by medical schools, the Johns Hopkins programs in East Baltimore and Columbia, Maryland, the Harvard Community Health Plan, and the three programs associated with Yale University. Other academic health centers are now involved in planning and development of HMO programs.

General Association Viewpoint

At the outset of this statement, the Association wishes to stress its strong support for the objectives and the general approach of the various legislative proposals before the subcommittee. They all provide federal support for the development of prepaid, comprehensive health services to defined populations in a framework that emphasizes preventive rather than curative action. This, we believe, is an arrangement that offers considerable potential for advancing the general health condition of the nation.

The Association particularly concurs in the legislation's effort to

approach the development of a rational framework for the delivery of health services as a matter of prime importance, rather than allowing it to emerge merely as a derivative of the development of a national health care financing mechanism. At the same time, it is essential that there be a coupling of the objectives sought in health services delivery and the capabilities of both the financing mechanism and the available health care resources.

The more detailed comments of the Association which follow are a consequence of sober assessments of the needed changes in the current health scene and the task of making such changes. As a result of these assessments, the Association will necessarily be critical of some of the provisions of some of the legislative proposals. Such criticisms are made, however, in a spirit of contributing positively to a major reordering of the American health care system. In the Association's view, it is wiser and more likely of success to begin a deliberate and carefully thought-through process of changing the health care system than to attempt to transform, in a single stroke, the complex and deeply entrenched pattern of providing health care in America.

HEALTH MAINTENANCE ORGANIZATIONS

The HMO in Context

The health delivery concept now commonly known as the health maintenance organization has grown out of the nation's 40-year experience with prepaid group practice. Prepaid group practice was initiated during the 1930s in a small, Elk City, Oklahoma, clinic and underwent its first large-scale implementation in the West Coast development of the Kaiser Foundation Health Plan.

Broadly defined, prepaid group practice is a health care delivery system accepting the responsibility for organizing, financing and delivering health services for a defined population. Operating principles which set apart

prepaid group practice from other health care plans, such as Blue Cross-Blue Shield, for example, include prepayment by subscribers for health services on the basis of fixed periodic payments; responsibility for organizing and delivering health services to a defined population; provision of a set of comprehensive, plan-provided benefits normally including a predetermined period of hospitalization; complete physician services, and laboratory, diagnostic and x-ray services; use of physicians in multi-specialty group practice; and compensation of physicians by a means other than fee-for-service.

Because the Kaiser-Permanente Medical Care Program is so frequently thought of as the model for prepaid group practice, its organizational pattern is commonly regarded as the only possible one. Actually a number of organizational patterns are possible. Kaiser-Permanente is perhaps the best known of the hospital-based plans, owning its own hospitals in which members receive care. Among non-hospital-based plans, which must supplement their programs with Blue Cross or similar insurance or contract directly with outside hospitals, the best known are probably the Group Health Association of Washington, D.C., and Health Insurance Plan of Greater New York. Variations on these patterns include physician-run plans, such as the Ross-Loos Medical Group of Los Angeles, for-profit plans, and academic health center plans, such as the Harvard Community Health Plan, Yale's Community Health Care Center Plan, and Johns Hopkins' Columbia Hospital Clinic Foundation.

Prepaid group practice has developed in settings offering the consumer an option between prepaid group practice and other health delivery methods. Such an option should be retained in the development of health maintenance organizations.

Senate Legislation

Previous hearings in the Senate have taken testimony on a number of pieces of legislation to increase and expand physician training, health care generally and health maintenance organizations. They included:

-- S 703, the Minimum Health Benefits and Health Services Distribution and Education Act, a bill to provide minimum health benefits to employees and their immediate families and to provide for the distribution of health benefits and for medical education.

-- S 837, the Local Comprehensive Health Services Systems Act, a bill to provide federal assistance to develop local comprehensive health service systems.

-- S 935, the Physician Manpower Support and Services Act, title II of which is to encourage and assist academic health centers in the establishment of health maintenance organizations.

-- S 1182, the Health Maintenance Organization Assistance Act, a bill to provide assistance and encouragement for the establishment and expansion of health maintenance organizations.

-- S 1301, the Community Medicine Act, a bill to improve the quality and availability of medical care in communities presently lacking in adequate medical care services.

The Association of American Medical Colleges testified on these legislative proposals in a statement presented to the Health Subcommittee on October 5, 1971. Since then a major new legislative proposal has been introduced. It is S 3327, the Health Maintenance Organization and Resources Development Act, titles I and II of which provide assistance and encouragement for the establishment and expansion of health maintenance organizations and health service organizations.

The newest proposal authorizes a combination of grants, loans, and loan guarantees and interest subsidies to support planning and feasibility studies,

initial development costs, certain construction costs, and initial costs of operation. The assistance is available for health maintenance organizations and health service organizations. The principal differences between the two delivery systems are that health service organizations may be excused from providing services through a group in sparsely populated areas; may offer a less comprehensive package of health services than the HMO package and are restricted to operations in rural or non-metropolitan areas.

A health maintenance organization, for example, is required to provide the following comprehensive health services: physician services (including consultant and referral services); inpatient and outpatient hospital services; extended care facility services; home health services; diagnostic laboratory and diagnostic and therapeutic radiologic services; physical medicine and rehabilitative services(including physical therapy); preventive health and early disease detection services; vision care and podiatric services; reimbursement for expenses incurred for necessary out-of-area emergency health services; mental health services (including drug abuse and alcoholism), utilizing existing community mental health centers on a priority basis; dental services (including preventive dental health services to children); provision of or payment for prescription drugs; and other services as determined by the HEW Secretary.

A health service organization, by contrast, is required to provide initially only those comprehensive health services which the HEW Secretary determined the HSO was capable of providing and may merely indicate plans for expanding the services to the full HMO-size package.

Other provisions of the bill preempt restrictive state laws and allow health services for first Americans to be provided through HMOs and HSOs. In addition, the bill requires HMOs and HSOs as a precondition to federal assistance to comply within two years with standards set by the Commission

on Quality Health Care, established by title IV of S 3327. The bill also establishes a health maintenance trust fund to finance annual grants to HMOs and HSOs serving persons who cannot meet the expenses of such a group's premiums. Finally, title V of S 3327 authorizes grants for training programs in the management and administration of health maintenance organizations and health service organizations and grants for clinical training provided by HMOs and HSOs to cover expenses associated with education.

Association Comments

The Association of American Medical Colleges supports the concept that access to adequate health maintenance and care is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system. The system must be a national one, with adequate provision for varying regional requirements. Universal entitlement should be based on financing from both public and private sources, either through insurance or prepaid group practice plans. Control of the system and fixing of national health goals and priorities require appropriate balance between public and provider inputs. Any system must assure simple and understandable access to primary care and prompt referral, in accord with individual patient needs, to progressively more sophisticated facilities and personnel. It must provide for, and emphasize, preventive as well as curative care on an ambulatory basis. The system should optimize quality of care and economy and should utilize incentives as an aid in cost control and in developing a more effective and responsive national mechanism for the delivery of health services. It must include a method for evaluating the overall operation and performance of providers.

Following are specific Association comments on what appear to be the key policy questions contained in the legislation.

Comprehensive benefits -- There can be no compromise with the goal of developing a national system capable of providing a full range of comprehensive

health care services to all the people of the nation. This is the only adequate response to the high priority that every socioeconomic level of society places on health. At the same time, it would be sad indeed if the Congressional action to achieve this goal specified the essential package of services which must be immediately available in order to qualify for federal support in such terms that few organizations could command the resources to provide them and only a few persons or groups of persons could afford to purchase the package. The inevitable result would be the stillbirth of federally supported health maintenance organizations. To avoid such a situation, the Association suggests a more flexible definition of what shall constitute a health maintenance organization. Thus, to qualify as an HMO, an organization would be required to embody the following characteristics:

1. The organization or group of cooperating organizations constituting the HMO shall constitute a comprehensive health-care delivery system with clearly identifiable points of responsibility for all managerial, administrative and service functions.

2. It shall assume responsibility for providing or effectively arranging for reasonably comprehensive health care services including at least physician services (including consultant and referral services); inpatient and outpatient hospital services; members' health education services and education in the appropriate use of health services; diagnostic laboratory and diagnostic and therapeutic radiologic services; rehabilitation services (including physical therapy); preventive health services; emergency health service; out-of-area emergency health services; and such other personal health services as the HEW Secretary may determine are necessary to insure the protection, maintenance and support of human health, including health-center transportation and special services for the poor.

3. It shall receive compensation for such services to its enrolled participants primarily on the basis of a predetermined actuarially sound,

periodic rate; however, it may also serve non-enrolled beneficiaries on a fee-for-service basis and may require modest copayments as agreed upon in advance to supplement its periodic rate with respect to certain services to enrollees.

4. It shall be responsible for providing all covered services for a contract period within the revenue provided through the predetermined rate and copayment method of reimbursement, under arrangements whereby the organization bears, and the cooperating units within the organization share, financial responsibility for the appropriate and effective utilization of health care resources to meet the health care needs of the enrollees.

Open enrollment -- The issue of open enrollment in health maintenance organizations presents a hard choice between idealism and pragmatism. Unquestionably, the goal should be to accept periodically individuals in the order in which they apply, regardless of their health status or the requirements for providing their health services. Some universal financing mechanism, however, is essential to the achievement of such a goal. There is no universal financial entitlement at the present time, of course; and unless all carriers provide it, mandatory open enrollment for federally underwritten HMOs would place them in a fiscally untenable position. This would be so because mandatory open enrollment imposed on HMOs but not on other health care arrangements would tend to generate a character of HMO membership that was actuarially unsound in the face of any conceivable financing arrangements. This becomes apparent when one considers the relative attractiveness of HMO membership to a large family with chronic, high-cost, health care needs. Multiply the financial impact of this family's enrollment by any sizable number of similar families living in, or moving to, the same HMO service area, and the potentially disasterous financial picture for the HMO comes into clearer focus.

To deal with this situation within the realities of present financing mechanisms, the Association recommends development of some appropriate legislative provisions to encourage HMO enrollment of high-risk populations, perhaps through some form of additional, special reimbursement. At the same time, the Association strongly urges replacement of the mandatory open enrollment provisions by suitable language emphasizing a progressive HMO enrollment policy aimed at producing an HMO membership whose demographic composition was representative of the geographic area being served.

Medically underserved areas -- The Association supports without reservation the emphasis in the legislation to extend health services to underserved areas. The Association hopes there is a clear understanding that special levels of health staffing and health care promotion will be required for the successful development and operation of HMOs in such areas. All the same, the Association is concerned that well-intentioned efforts to include representation of broad socioeconomic groups in health maintenance organizations do not result in unintended adverse side-effects. It would be unfortunate, for example, for a legislatively mandated percentage of membership from medically underserved areas to prevent a health maintenance organization from offering membership to neighboring residents. Rigid requirements for enrollment from medically underserved areas -- whether conceived of as a floor or as a ceiling -- could, in the view of the Association, be counterproductive. They could lead, for example, to grotesque gerrymandering of HMO service areas. They could lead to actuarially unsound enrollments. In place of such rigid limits, the Association

recommends development of language that would permit the HEW Secretary to determine on a case-by-case basis that federally supported health maintenance organizations contained a reasonably representative proportion of enrollees from medically underserved areas.

Preemption of state laws -- Because of its overriding interest in the development of health maintenance organizations, the Association is particularly concerned by the existence in many states of legal barriers to HMO development. These barriers take the form of laws that restrict group practice, the corporate practice of medicine, advertising and other practices. The Association supports enactment of legislative proposals for the federal government to preempt such restrictive state laws and to assist states in amending their existing laws.

Clinical, management training -- The education of health personnel must be closely related to the system for providing health services. As the HMO concept diminishes the traditional process of dealing with illness only when it occurs, and generates a new emphasis on maintaining health, health personnel must be trained in the context of this changed approach. In fact, as future physicians and practicing health personnel, they must become thoroughly involved as students in the principles and techniques of preventive care for this shift in emphasis to occur. Thus it is important for medical students, interns, residents and other health professionals to have their clinical training within a framework which provides for the delivery of comprehensive, primary health care in a setting that stresses preventive care and the use of a variety of health personnel in a team approach. When this

happens, there are certain additional educational costs incurred, which must be met. The Association urges enactment of federal assistance for the purpose of covering these additional HMO expenses associated with the clinical training of health personnel, so that such costs are not borne by HMO enrollees. Since health personnel may receive a portion of their clinical training in a variety of HMO settings, the Association suggests that clinical training grants to cover these costs be equally available for accredited programs in all teaching HMOs.

Recognizing the difficult problems surrounding the start of an HMO and the great sophistication HMOs require in the areas of management control, marketing, contract negotiation, capital budgeting and financing, the Association urges enactment of federal assistance for training programs in HMO management and administration.

Quality of care -- Since pending legislation proposes to provide significant federal support for the development of the health maintenance organization concept of health service, and since that concept stresses new patterns in health care delivery, it is essential to assure that these new organizations provide the highest quality of care. Nationwide uniformity of standards is imperative for the development of national confidence in this new form of health care delivery. To meet these needs, the Association supports establishment of a mechanism within the federal government to set norms and standards for the delivery of health services. Standards of excellence in the provision of health care must be set and maintained.

For this purpose, the Association urges enactment of the following federal mechanism for setting quality-of-care standards:

1. Creation of a five-member, Presidentially appointed Commission on Quality Health Care.

2. Creation of a 12-member, Presidentially appointed National Advisory Council on Quality Health Care, comprised of suitably experienced and broadly representative members from the health professions, the academic health community, business, labor and other consumer interests, which shall advise and assist the Quality Health Care Commission.

3. Authority for the Commission, with the approval of the Advisory Council, to develop and establish within two years appropriate quality health care standards and to prescribe necessary quality control systems.

4. Authority for the HEW Secretary to administer the resulting federal health care quality standards system and to provide technical assistance to health care providers in the development of quality control programs.

5. Transfer to the Commission of the National Center for Health Statistics and other appropriate functions as determined by the President.

These suggestions are not greatly different from some of the provisions of some of the legislative proposals currently pending before the Congress.

The Association is uncertain whether the Commission -- as a policy-making body -- should be established as an independent agency, separate from the Department of Health, Education and Welfare, or as a Department agency. There seem to be reasonable arguments for and against both approaches. The advantages of independence revolve around the problems of conflict of interest when the same federal agency is responsible for promoting and regulating a certain service. The disadvantages of independence revolve around the problems of further fragmentation of the federal health structure when a major, new, federal health agency is established outside the framework of the principal federal health establishment. Perhaps strong public participation through the Advisory Council in the actions of the Commission would offset the inherent conflict-of-interest situation if the Commission were located in the Department. The location of another major regulatory agency, the Food and Drug Administration, within the Department obviously provides some precedent for locating another regulatory agency within the Department.

The Association is clear in its decision to recommend administration of the federal health care quality standards system by the HEW Secretary. Only in this way can creation of yet another massive federal administrative bureaucracy be avoided. The necessary administrative organization already exists within the Department of Health, Education and Welfare. The Association is convinced that it should be utilized.

Initial HMO financing -- Health maintenance organizations represent an innovation of great potential and considerable complexity. Financing for these programs should be at a level and for a duration sufficient to assure flexibility for experimentation in the full range of settings in which an HMO may exist. The programs should be fully funded for the duration of their planning, developmental and early operational phase, specifically until enrollment is at a level that provides sufficient premium income to finance operations. There should be a single source of federal funding for these programs. Frustrating efforts to obtain financing and participation from numerous federal and state programs are a strong deterrent to participation in HMO development. The time, effort and complexity involved in such a fragmented approach will discourage many potential HMO sponsors from becoming involved in HMO development.

Both the time period and the budget for start-up must be realistic. In some instances two to three years may be sufficient but other longer periods may frequently be justified. One-year availability of funds is clearly inadequate. There is little in the way of real experience as to how long the start-up period should be. Numerous authorities have pointed out the difficulties that are involved in marketing and enrollment in communities where there is no experience with prepayment or an absence of large definitive groups that can be enrolled. Intense marketing activity may be required

long after the first enrollees have received care from the program.

In relation to capital finance, two types of support are required. Funds for construction and renovation are necessary because existing facilities are unlikely to meet needs for the organization of services required in an HMO. FHA mortgage and guaranteed loan provisions are associated with substantial negotiations and delay, and at the end point mortgage or loan dollars may only be available at very high interest rates. There is also need for initial working capital. In HMOs established to date, enrollment has lagged to such a degree that HMOs required outlays far in excess of what they took in in premiums for a considerable period. The full range of services, however, must be available to the first enrollees in the program. Therefore, the HMO requires support for a sufficient period to assure enrollment to a break-even point.

Health care financing -- Perhaps the most serious issue in the ongoing operation of health maintenance organizations is the matching of premium income to the cost of providing health care services. Inherent in the concept of a health maintenance organization is the provision of a comprehensive package of health services. Although reasonable persons may differ over the makeup of a comprehensive health care package, the implicit corollary of any package is that it can be supported through premium income, either from enrollees or from third-party payers. A commonly regarded source of such financial support is a program of national health insurance geared to provide reimbursement for the services provided by a health maintenance organization. Again, as with the financing of initial HMO development, there should be a single source of funding for the federal share of joint public-private health care financing. Such a national health care financing system would

eliminate the present frustration of attempting to reconcile varying packages of services for which reimbursement is provided, varying funding cycles, varying -- and sometimes conflicting -- guidelines, and varying funding levels.

Thus, it seems clear that an essential interrelationship must exist between the legislative development of a national health insurance system and a national health delivery system. Since the present realities of the legislative process dictate that separate committees consider these matters, two courses of action appear possible. One is to allow the services subject to reimbursement through national health insurance to become the services required of a health maintenance organization. This in effect permits the financing to determine the program. The other course of action is to develop an imaginative, progressive, comprehensive health delivery system and to rely on the will of the people to urge enactment of an appropriate financing mechanism. This would follow the current practice of legislation authorizing a federal program, followed by subsequent legislation relating to the funding for the program. The record of the current practice in providing sufficient funding levels is not encouraging, however.

Faced with these equally unpalatable choices, the Association wishes to suggest a third alternative. We suggest the development of a system of mutual working relationships between the legislative committees charged with developing a national health insurance program and the legislative committees charged with developing health care delivery systems. These relationships could take the form possibly of select committees in each chamber comprised of members of the appropriate standing committees, or of a joint committee comprised of members of the appropriate standing committees of both chambers.

At least there should be an agreement of multiple referral for legislative provisions dealing with health care financing and health care delivery. Such an arrangement -- in whatever form it developed -- would permit those concerned more directly with health legislation to work closely with their colleagues concerned with health care financing to develop a coordinated program to meet the health needs. Under such an arrangement, a national health program would not be the product of financing considerations alone, and the substantive health committees could gain the understanding and support of those with the charge of providing federal support for health care through the Social Security system or a national health insurance plan.

Federal malpractice insurance -- Litigation of medical malpractice claims has become a burdensome and unsatisfactory means of achieving a fair result for both the provider of medical care and the patient. Physicians have become increasingly apprehensive as the insurance rates for malpractice protection increase alarmingly and the specter of protracted law suits arises ever more frequently. The Association agrees with the need for a major change in the current approach to medical malpractice litigation. Accordingly, it urges enactment of a modified form of the federal medical malpractice insurance program proposed in S 3327, the Health Maintenance Organization and Resources Development Act. To avoid duplicating an existing bureaucracy capable of administering such a program, the Association urges that administration of the federal medical malpractice insurance program be assigned to the HEW Secretary. This modification of the Senate proposal, which places administration of the program in the Quality of Health Care Commission, is in line with suggested alterations in the duties of the Commission proposed elsewhere in this statement.

AREA HEALTH EDUCATION CENTERS

Senate Legislation

Title III of the Health Maintenance Organization and Resources Development Act (S 3327), authorizes, among other things, a new program of assistance to university health centers or to regional medical programs (where they exist) for creation of area health education and service centers. Assistance is to be provided through a combination of grants and loan guarantees and interest subsidies to help meet the costs of development, construction and initial operating expense. Additional assistance is provided through grants for training programs in the management and administration of area health education and service centers and through grants for clinical training provided by such centers to cover expenses associated with education. The bill includes the new assistance program for area health education and service centers as part of a new title XI of the Public Health Service Act, which also includes new programs of assistance for health maintenance organizations and for health service organizations. In addition, the bill amends title IX of the Public Health Service Act, dealing with regional medical programs, to authorize assistance under that title also to area health education and service centers.

S 3327 defines an area health education and service center to mean the following:

"...a hospital, educational facility, or other public or private nonprofit entity affiliated with a university health center for the purpose of providing clinical training in a non-metropolitan area (other than an area presently served by a university health center) which (A) has an agreement with a health maintenance organization or health service organization (if such an

organization exists within the geographical area served by such center) to provide education services to, and health care services through such organization; (B) has an agreement with other providers of health care to provide education services to, and health care services through such center; and (C) provides, to all licensed health professionals in the geographic area which it serves, equal opportunity to use its facilities and programs."

Association Comments

The Association of American Medical Colleges fully recognizes the continued importance of bringing academic health center functions into meaningful engagement with the advancement of community health, insofar as academic health center functions can appropriately contribute to those objectives.

The concept of the area health education center, as developed by the Carnegie Commission on Higher Education, viewed it as in essence the linking mechanism between the university health science center and the community health service scene. Through this mechanism, the educational capability and functions of the university health science center could be extended to join with, participate in, and contribute to the advancement of the health functions and activities in the community setting -- to the degree to which these could be influenced through educational programs, research and development and demonstration of innovative service programs. The Association is convinced of the real need for such a coupling mechanism which should be considered an essential element of the nation's overall health apparatus. There are many important contributions that these arrangements can make in advancing the overall effectiveness of that apparatus. Among the more

important are:

...Education of health professional students in settings other than conventional metropolitan academic health centers would provide opportunities for students to gain first-hand knowledge in their formative years regarding the health problems and the social, cultural and economic characteristics of Americans living in the more sparsely settled regions.

...Educational opportunities would be provided for many students dwelling in sparsely settled regions who are seeking careers in the health field.

...Practicing health professionals would have opportunities to participate in continuing education programs within their own environment yet with full access to academic health center resources.

...Research in the organization and delivery of health services and the evaluation of health programs utilizing academic investigative capability would be made possible.

... The improvement and enlargement of laboratory and other technical health services would be facilitated.

...Resources for public education in community and personal health care would be expanded.

The Association thus supports the urgent need for federal assistance in the development of new arrangements to bring the academic health center function into meaningful engagement with the advancement of community health. The important word here is "meaningful," and the Association strongly believes that to be meaningful, an area health education center must serve primarily educational, research and technical assistance roles. Such roles must not exclude service; they must, however, maintain the service function in proper perspective.

The key matter to be emphasized is that such arrangements must be flexible to fit with the special needs and conditions to be met in the various areas of the country and the different institutions involved. The Association believes it unwise to legislate in statutory terms a single form and set of functions for area health education centers, such as provided in S 3327. The Association also objects to defining the term "university health center" as comprising only the "health care institution" operated by or affiliated with a university or college of medicine, as proposed in section 1101(7) on page 9 of S 3327. In the Association's view, a "university health center" necessarily encompasses the academic and educational components as well as the health care components of an academic institution.

In the Association's view, the committee can add appropriate language in its report to make available for assistance to area health education centers present authority for federal support of new arrangements to serve as linking mechanisms between the academic health center and the community health service scene. The recently enacted Comprehensive Health Manpower Training Act authorizes a broad program of health manpower education initiative awards to improve the distribution, supply, quality, utilization and efficiency of health personnel and to foster new arrangements for their education. Appropriate use of this authority could provide a flexible basis for federal assistance in the development of useful new and innovative arrangements for joining the academic and community health scenes -- whether the arrangements are called area health education centers, area health education and service centers, or something else.

EXTENSION OF OTHER PUBLIC HEALTH SERVICE PROGRAMS

Senate Legislation

Title V of S 3327, the Health Maintenance Organization and Resources Development Act, extends virtually without change a number of federal health programs which are due to expire June 30, 1973. Among them are section 314 of the Public Health Service Act, dealing with comprehensive health planning, section 601 relating to the Hill-Burton Program and title IX of the Public Health Service Act, dealing with Regional Medical Programs.

Association Comments

The Association recognizes the desirability of early Congressional action on health programs whose authorities will expire in the coming fiscal year. However, the roles and functions of most, if not all, of the programs whose extensions are authorized under title V of S 3327 will be affected to a more or less substantial degree by whatever emerges as the finally enacted form of titles I through IV of the bill. This is particularly true of Comprehensive Health Planning and Regional Medical Programs, as well as of the Hill-Burton program.

CHP and RMP constitute the principal federal mechanisms for relating to public and private health activity on a regional, state and local basis. CHP has been centered on developing the framework and improving the planning for comprehensive health services at both the state and local levels. A new and substantial federal initiative for the development of health maintenance organizations and health service organizations, and the major role such entities will play in the organization and delivery of health services, have obvious implications for the further evolution of CHP and the federal objectives sought

through that program. RMP has been basically directed toward improving the quality and availability of health services through the support of regional arrangements involving the providers of health care. Again, as in the case of CHP, the major expansion of HMOs, and particularly, the role and functioning of the Commission on Quality Health Care, may greatly modify both the setting and functions of RMP. In a similar manner, the Hill-Burton program of federal assistance for the construction of health service facilities may need modification to assure accomodation to the pattern of facility needs which major use of HMOs may generate.

It is, therefore, the view of the Association of American Medical Colleges that consideration of the program extensions contained in title V of S 3327 be delayed until after completion of Congressional action on titles I through IV of the bill. This might be accomplished by encompassing title V in a separate bill, upon which hearings could be heald once S 3327 is enacted.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON CERTAIN APPROPRIATIONS FOR THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE FISCAL YEAR 1973*

Mr. Chairman and members of the subcommittee:

The Association of American Medical Colleges welcomes this opportunity to appear before the subcommittee during its consideration of the President's fiscal 1973 budget for the health programs of the Department of Health, Education and Welfare.

Formed in 1876 to work for reforms in medical colleges, the Association has broadened its activities over the years, so that today it represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 108 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 52 learned academic societies whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all of the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It is concerned with the delivery of health care, directly through the facilities of teaching hospitals, and indirectly through the development of improved community health services. It is

*Presented by John A.D. Cooper, M.D., President of the Association of American Medical Colleges, before the Labor-HEW Subcommittee of the Senate Appropriations Committee, May 25, 1972.

concerned with innovation and experimentation in all of these fields. The Association and its membership thus have a deep and direct involvement in the many programs whose appropriations requests this subcommittee is now reviewing.

The Need for Action

The Association of American Medical Colleges feels strongly that the nation has made a clear and loud call for an expanded and concerted attack against the health care crisis. To provide the additional funds for such a concerted attack in this critical period of fiscal disorder is, indeed, a task demanding the wisdom of Solomon. In the process, current patterns of spending on all federal programs must be scrutinized carefully for their relevance to the needs of the nation. We are certain that health must emerge from that scrutiny as among the highest national objectives.

In his January budget message, the President pointed out that his recommendations would "...enable us -- for the first time -- to

spend more in the Department of Health, Education and Welfare than we spend in the Department of Defense." The President's declaration, while arithmetically correct, has given rise to much confusion and has produced an understandable reaction against major increases in health spending. Because of this, the Association considers it useful to set the Administration's health budget in its proper context.

The key problem is the nature of the budget structure of the Department of Health, Education and Welfare. Total new budget authority proposed for the Department in fiscal 1973 is shown in the budget as $86.6 billion, an increase of $10.4 billion over fiscal 1972. In contrast, it is pointed out that the budget for the Department of Defense for fiscal 1973 is only $81.8 billion, an increase of $4.7 billion over fiscal 1972. These are the figures which form the basis for the Administration's statement. They overlook the fact that $60.8 billion of the Department of Health, Education and Welfare's budget constitutes trust funds that are specifically committed by law to Social Security and Medicare programs, and, therefore, are not subject to discretionary use by the President. That part of the Department's budget which is available for discretionary use by the President -- and thus represents the true budget commitment by this Administration to human resource activities is $28.7 billion, an increase of only $1.3 billion over the level of the same programs in fiscal 1972. In fiscal 1973, therefore, the Administration is proposing to add almost four times as much to the defense budget as it is proposing to add for programs in the Department of Health, Education and Welfare.

There is another, equally important aspect of the Administration's budget for fiscal 1973 as it relates to health. The budget shows that total federal outlays for medical and health-related activities will reach $25.5 billion in fiscal

1973, an increase of $1.8 billion. Of the $25.5-billion total, however, four-fifths, some $20 billion, is spending for Medicare or Medicaid programs and the operation of federal medical programs for the armed services, the Veterans Administration and other federal beneficiaries. Only one-fifth of the total, some $5.5 billion, is spending for programs aimed at changing and improving the health conditions of the nation as a whole. These are programs for health research, for the training and education of health personnel, for improving the organization and delivery of health services, and for the prevention and control of health problems. What this means is that the bulk of federal health spending is concentrated on sustaining the status quo of the present system, which is increasingly acknowledged as inadequate, inefficient and unresponsive. Only a lamentably small amount of federal health spending is for programs whose objectives are innovation, change and improvement.

The Association would like now to comment in some detail on those elements of the Administration's budget which directly affect the capability of the nation's medical schools and teaching hospitals in advancing the national attack upon our health problems. While the Association has a deep concern with all health programs covered in the budget, in the interest of brevity and emphasis, this statement concentrates on those programs upon which the national role of its institutional constituents is vitally dependent. In addition to speaking for its own constituency in this statement, the Association is also commenting as a member of the Coalition for Health Funding. The Coalition is a 23-member group of organizations with broad interests in all aspects of health care. The Coalition is nonpartisan and limits its efforts to the annual federal budget and the appropriations process of the Congress. The Association is in full support of all of the appropriations increases recommended by the members of the Coalition.

Education of Health Professionals

The shortage of health personnel has been identified as the single most critical deficit facing the nation in all of the discussion surrounding alternative national health insurance legislation. Schools of the health professions have made great efforts and are in the midst of further efforts to expand their programs to meet this shortage. This whole process of expansion and, in fact, the very survival of the academic institutions involved has been threatened by rising costs and shrinking sources of income, coupled with inadequate and unstable assistance from the federal government. Recognizing these problems, Congress last year moved to provide health professions schools with substantial and continuing federal support by enacting the Comprehensive Health Manpower Training Act of 1971 (PL 92-157). In signing the provisions of the Act into law, the President said: "...they constitute the most comprehensive health manpower legislation in the nation's history. But legislation is only a first step. These new programs must now be adequately funded and effectively carried out."

The Association could not agree with the President's statement more. Therefore, we were bewildered and disappointed by the Administration's fiscal 1973 budget recommendations for those NIH programs which support health professions education. The Administration requested a total of $331,433,000 for these programs, compared to fiscal 1972 Congressional appropriations of $460,341,000. The Administration's request thus represents a cutback of $128,908,000 from last year's level of funding and wipes out funds for construction grant assistance. This action threatens to turn last year's landmark legislation into vain rhetoric.

Regardless of the way the budget is examined, the picture is most discouraging. The requested appropriations are an outright reversal of major proportions in the newly enacted national program to overcome health personnel shortages -- an effort that is critical to the health of the nation. Denial of construction grant

funds eliminates one of the three principal categories of aid in the Comprehensive Health Manpower Training Act and destroys in a single blow the unity of what was envisioned as a coordinated, interlocking, federal effort to assist health professions education.

Enactment of the Comprehensive Health Manpower Training Act marked the first time that Congress had enacted legislation recognizing medical education as a function of national importance and recognizing the academic institutions providing such education as national resources. The legislation is based upon three broadly interrelated areas of assistance -- construction assistance, institutional support, and student assistance. Construction assistance is to be provided through grants, supplemented where feasible with a system of federally guaranteed loans. Institutional support is to be provided through a mutually supporting combination of capitation awards (based on the number of students enrolled), base grants for small schools, bonus awards for enrollment increases, incentive awards for training physicians' assistants, special assistance to new schools, initiative awards to support efforts aimed at alleviating deficiencies in the supply, utilization and quality of health professionals, and emergency grants to schools in serious financial distress. Student assistance is to be provided through loans and scholarships, with special traineeships and fellowships available for primary care physicians and health professions educators. In addition, the legislation authorizes assistance for some postgraduate training and for applying computer techniques to health professions education.

The legislation was designed so that all of these several activities could operate as a single, coherent program to assist health professions schools in meeting national objectives. As the Senate Labor and Public Welfare Committee's report declared: "This bill is designed to establish a coherent and explicit federal role with regard to the support of the

education of health manpower." The report of the House Interstate and Foreign Commerce Committee added: "The bill is designed to accelerate increases in health professions personnel and to effect changes in their distribution. The health manpower effort must have both a qualitative and quantitative impact on the health services of the nation." These views appeared to be shared by President Nixon. His 1971 health message said, "...we must rationalize our system of financial aid for medical education so that the schools can make intelligent plans for regaining a sound financial position." His 1972 health message said the new legislation "...will spur the greatest effort in our history to expand the supply of health personnel."

The appropriations requests of the Administration reflect no acceptance of this Congressional view of the mutually supportive nature of the various elements of the Comprehensive Health Manpower Training Act. Nor do the requests provide the level of support in the key program areas upon which achievement of the objectives sought is completely dependent.

Construction Assistance

The expansion of the nation's medical education resources requires continued and sustained capital expansion in terms of the educational facilities required. Failure to provide adequate funding for the construction grant programs jeopardizes the entire planned response of the nation's health professions schools to their required expansion. Increasing federally guaranteed construction loans is no substitute, because reliance on debt financing for construction of buildings on which interest and amortization costs cannot be covered by the income they generate is unrealistic and inappropriate. Many of the public institutions involved are prohibited by law from incurring debt.

If the medical schools are to increase their enrollment at the pace

required in the legislation, they must be able to expand and improve their existing facilities. The schools desperately need more teaching space and more facilities for self-instruction. In addition, there is a growing need for extensive renovation and replacement of the aging, inefficient buildings which some of the older schools of the health professions are forced to utilize at high maintenance costs.

It is the understanding of the Association that schools with previously approved but unfunded construction grant applications must reapply under the procedures of the new Comprehensive Health Manpower Training Act. The measure of that backlog was $614 million, of which $350 million represented projects with matching funds committed, plans completed and ready for bid. It seems reasonable to assume that the vast majority of schools will reapply. This backlog, coupled with the construction needs of planned new schools and the further expansion needs of existing schools, creates an intolerable situation. In view of the economics involved and the urgent task ahead of meeting the nation's need for physicians, the Association urges the reinstatement of the construction grant program at a level that would make possible a substantial reduction in this urgent backlog. Such action appears essential to maintain the mutually supportive nature of the elements of the new legislation.

Institutional Support

Operating costs for medical schools have increased at a substantial rate throughout the post-war period. The inflationary price-wage trend has, of course, been an important factor in these increases. Perhaps the greatest influence has been the effect of the vast changes in the functions, programs and services involved in present-day medical education. Social demands on the teaching, research and service functions of the institutions are at their highest; operating costs have risen at unprecedented and unanticipated rates; levels of operating income have lagged seriously behind the increase in expenses; and the substantial and heretofore stable flow of funds for research and research training has undergone cutbacks and program shifts.

This perilous financial situation and the critical need for a substantial level of stable operating support was laid before the Congress last year during action on the health professions education assistance legislation.

It was the estimate of the Association of American Medical Colleges that an appropriate sharing of medical school operating costs among federal, state and private sponsors required federal grants providing $5,000 per medical student per year. The Carnegie Commission, in its report, Higher Education and the Nation's Health, recommended federal support for medical and dental education at $4,000 per student per year. The health professions education assistance bill which passed the Senate set the level of support at $4,000 per student per year, with a $50,000 base grant for each institution. The final law passed by the Congress, the Comprehensive Health Manpower Training Act of 1971, contained the House-passed levels of support, which were $2,500 per student per year for the first three years plus $4,000 per graduate. (The final bill also included a Senate-passed provision of $6,000 per graduate from a three-year program. The $4,000-per-graduate bonus is for graduates of four-year programs.) In addition, a House requirement that capitation support be

contingent upon mandatory enrollment increases was also enacted. Additional awards were provided -- supplementing the basic capitation awards -- for voluntary enrollment increases above the minimum mandatory level and for other special programs such as the training of physicians' assistants.

The basic legislative concept of the new law was that in return for a specific enrollment expansion, a given level of federal capitation support would be provided. In addition, funds for special financial assistance grants were separately authorized in decreasing amounts. These special financial assistance grants are to be terminated in three years on the explicit assumption that the levels of basic capitation support authorized in the law would eliminate further need for such special assistance.

The Association details these aspects of the new law to emphasize the interdependence of the several provisions relating to basic operating support and to demonstrate how destructive of this concept are the funding levels provided in fiscal 1972 and requested in the Administration's budget for fiscal 1973.

The Administration is demanding that the schools meet the full letter of the law in carrying out enrollment increases, while requesting appropriation of only two-thirds of the funds authorized for this purpose. These enrollment expansions are being undertaken at substantial expense to meet national requirements. At the same time this burden is being ignored, if not rejected, in the Administration's budget. The Association believes this constitutes a substantial breach of faith with a set of institutions which throughout the entire postwar period have served the nation's need with a minimum level of basic operating support in return.

Capitation support under the new law, totaling $11,500 per student in a four-year program and $13,500 per student in a three-year program, is set through

what amounts to a formula process: a specific amount of support per student or per school under a set of specific conditions. Thus it is possible to calculate with some precision the total amount required to meet the terms of the legislation. For the various programs authorized in section 770 of the new Act, the medical schools of the nation qualify in fiscal 1973 for a total of $150,000,000. This includes $137,300,000 in regular capitation grants, $10,700,000 in bonus enrollment awards, $650,000 in base grants to small schools, and $889,000 in incentive awards for training physicians' assistants.

Against these demonstrated requirements, the Administration is requesting $96,500,000.

Additional funds must be provided if the capitation system of support is to operate as Congress intended. The intent of Congress is clear. The report of the House Interstate and Foreign Commerce Committee said: "The capitation grants are designed to provide a dependable support base for the educational programs of the health professions schools without having to go through the 'back door' of research to support education." Added the report of the Senate Labor and Public Welfare Committee: "The covert support of educational programs through the research grant mechanism is not in the public interest, and it is an inadequate mechanism for that purpose." It is estimated that the fiscal 1973 appropriations requested by the Administration will barely reach 65 percent of the authorized levels for capitation support -- providing an average of $1,775 per student and $2,828 per graduate. The Association is not convinced that the Administration's request meets the Congressional mandate of "...a dependable support base..."

It may be helpful in this connection to share with the Committee some of the problems with which medical schools are confronted, in the absence of full level of capitation support. The mandatory increased enrollment

required by the Act forces schools to provide the staff, teaching facilities and other resources for the additional students, as well as to develop programs specifically designed to assist increased numbers of minority and disadvantaged students. In the absence of full capitation, a substantial number of schools will have to undertake emergency action to defray these unmet costs. This action will include increasing tuition, seeking difficult-to-obtain additional assistance from private and public sources, and, in those instances where still available, using endowment principal. Such action will leave the schools with little or no fiscal reserves. Because of the precarious circumstances that this situation will generate, it is evident that quality standards will be threatened, and that special programs to assist minority students will have to be curtailed, results that no one wants to see occur.

The special project grant program of the new law offers the opportunity to stimulate major innovation in the form, direction and effectiveness of educational programs for health professions. In the past, it never has been possible to realize the full promise of this opportunity because a considerable part of the funds appropriated for this purpose have consistently been diverted to provide emergency financial assistance. The new Act separates the funding of financial distress needs from special projects financing. This arrangement would make it possible to realize the full objectives of the special projects program, if it were adequately funded. Unfortunately, the Administration is requesting only $43,000,000 for special project grants to medical schools compared with the $138 million authorized in the new legislation. The $43 million requested will barely cover the funds required to meet prior commitments under this program, thus leaving no funds for new projects.

Fortunately, the Administration is requesting appropriation of the full

authorization for financial distress grants. These funds are desperately needed by some schools to sustain their financial operations and the quality of their educational programs. Even the fully authorized levels of capitation support would leave some schools in financial distress. The practice of partial capitation support makes their situation acute. In fiscal 1971 almost 60 percent of the special project grant funds awarded to medical schools went to meet some condition of financial distress. In fiscal 1972, medical schools were awarded some 58 percent of the financial distress funds. Substantial special assistance still is needed by some of the schools if they are to take full advantage of other federal educational assistance programs and are to carry their share of the burden of meeting the nation's health personnel shortage.

The new program of health manpower education initiative awards, authorized for the first time in the new Act, is to support projects to alleviate deficiencies in the supply, utilization, distribution and quality of health personnel. It is intended that the program will support new approaches to solving health personnel problems. The $20 million which the Administration is asking for this program in fiscal 1973 is exactly the amount appropriated by Congress in fiscal 1972 for this program. It is a pitifully small measure of the importance and difficulty of these manpower problems.

Again, it is important to emphasize that the various elements of the Comprehensive Health Manpower Training Act are intended to be mutually supporting. Increased funding of the institutional support programs is essential to provide the Congressionally intended dependable support base for the schools to meet their educational objectives.

Student Assistance

Adequate financial assistance for medical students is an inseparable part of the problem of expanding medical school enrollment. The Association

is unwaveringly committed to the view that medical school enrollment should reflect the demographic and socioeconomic mix of the national population. A substantial barrier to the full realization of that view is the inadequacy of available financial aid.

Congressional action on the Comprehensive Health Manpower Training Act of 1971 indicated an understanding of the problem of inadequate financial aid and a willingness to increase substantially the maximum annual assistance, from the previous level of $2,500 per student to $3,500 per student for loans and scholarships. In addition, the authority to provide financial assistance was extended for the first time to include U.S. students studying abroad and disadvantaged students from doctor shortage areas who agree to return there and practice.

A full-scale attack on the problem of inadequate student financial assistance is not possible, however, without higher funding of the program of student loans and scholarships. For the current academic year, the medical schools were entitled to $13 million in scholarship support under the formula in the new Act. Congress provided only $7.2 million. Medical school student aid officers requested $23 million in direct loan funds for the current academic year. Only about $16 million were provided -- barely two-thirds of what was needed. It is expected that in the 1972-73 academic year, the schools will need some $30 million in direct loan funds, compared to $19 million (less than two-thirds) allocated by the Administration. Against an entitlement of $13.8 million in scholarship support, the Administration is again requesting only $7.2 million.

The 1971 Act also provides special, new authority for traineeships and fellowships for the development and maintenance by hospitals of programs in family medicine. This new assistance is important for the training of the personnel necessary to provide better primary, personal

and comprehensive medical care to the American people. For these new programs of student assistance in fiscal 1973, the Administration is requesting appropriations of $57,500,000, an increase of only $6 million over the funds provided in fiscal 1972, and less than half of the funds authorized in fiscal 1973.

The Association urges that all these student assistance programs be funded at a level that will enable the schools to enroll a representative demographic and socioeconomic mix of the national population.

To carry out the intent of Congress and to meet the hopes raised by declarations of the President, the fiscal 1973 requests for appropriations to assist in the education of health professionals must be increased. They must be increased to allow the Comprehensive Health Manpower Training Act to do its job of helping to end the shortage of health personnel in this country. The old habit of setting one national goal in major, substantive legislation and another, lesser goal in subsequent appropriations is becoming increasingly difficult to explain to the American people.

To let the 1971 Act do its job will require a fiscal 1973 appropriations level of $795,513,000, an increase of $464,080,000 over the request of the Administration. A table is attached at the end of this statement which presents the Association's recommended levels of funding for the NIH programs of health professions education assistance. They are the most responsible recommendations we are able to develop, and we respectfully request thoughtful consideration of them.

Biomedical Research

President Nixon said in his 1971 health message: "If more of our resources were invested in preventing sickness and accidents, fewer would have to be spent on costly cures."

The Association agrees with the President's statement. Therefore, it was encouraged, at least briefly, by the Administration's fiscal 1973 budget recommendations for the NIH research programs. The Administration requested appropriations of $1,580,198,000 compared to fiscal 1972 Congressional appropriations of $1,434,361,000. The Administration's request represents an increase of $145,837,000. Close examination shows that the increase offers less than is apparent, however. And as the real situation became clearer, the Association's initial hope faded.

What a close examination shows is that more than 80 percent of the overall increase is concentrated in just two of the many programs and activities of the institutes. Appropriations for the National Cancer Institute and the National Heart and Lung Institute are to be increased by $117,647,000 -- $94,535,000 for the National Cancer Institute and $23,112,000 for the National Heart and Lung Institute. The remaining $28,190,000 is to be divided among all the other fields of research and investigation. Congress appropriated $864,523,000 in fiscal 1972 for these fields (such as dental research, arthritis research, population research and environmental health), so an increase of $28,190,000 represents an increase of some 3.3 percent.

Even with the most optimistic view of the efficacy of Phase II economic controls, a 3.3 percent increase in appropriations is a status quo action if not an actual cutback. There is, however, another inflationary process bearing upon the conduct of research which is beyond the reach of economic controls and which must be provided for if we are really seeking

to advance scientific effort. An inescapable attribute of the progress of science is that each additional effort to advance the frontiers of knowledge demands an increasing amount of energy. The biological and medical sciences have developed to the point where increasingly sophisticated equipment, facilities and technical services are essential to progress. This increasing cost of moving forward in the biomedical sciences is estimated at anywhere from 5 to 10 percent per year. Given these levels of cost increase, the Administration's budget constitutes a substantial cutback in most areas other than heart and cancer. The real situation is that the Administration is proposing to reduce federal support for most biomedical research rather than raise it. Such a course of action is the most nearsighted of false economies.

But even the Administration's proposed increases for the National Cancer Institute and the National Heart and Lung Institute fall far short of the mark.

Last year, Congress enacted major new legislation, the National Cancer Act of 1971, for an expanded national attack against cancer. The President signed the bill into law, with a brief ceremony in the State Dining Room at the White House. And in signing the bill, he said: "As a result of what has been done, as a result of the action which will come into being, as a result of signing this bill, the Congress is totally committed to provide the funds that are necessary, whatever is necessary, for the conquest of cancer. The President is totally committed..." The National Cancer Act of 1971 authorizes appropriations in fiscal 1973 of $530 million. The Administration is requesting $432.2 million. Obviously the President is reneging on his commitment. The Association urges Congress not to renege on its commitment.

This year, there are demands for a similar assault against heart disease, lung disease and stroke. Seemingly, the President agrees. He said in his written State of the Union Message: "The young father struck down by a heart

attack in the prime of life, the productive citizen crippled by a stroke, an older person tortured by breathing difficulties during his later years -- these are tragedies which can be reduced in number and we must do all that is possible to reduce them." The Administration is requesting appropriations of $255,280,000 for the National Heart and Lung Institute in fiscal 1973. Heart legislation currently pending in Congress authorizes appropriations in fiscal 1973 ranging from $370 million to $420 million. In the Association's view the sums recommended in the proposed heart legislation are far more realistic, with regard to actual needs, than those requested by the Administration.

Four additional areas deserve special comment. They are: (1) funds available for new and competing research grants; (2) the NIH general research support program; (3) the NIH fellowship and training programs; and (4) the animal resources activities of the Division of Research Resources.

Grants for New Research Projects

The Administration is proposing to reduce the funds available for new and competing research grants by $10,527,000 below the level set in fiscal 1972 appropriations. It is these new research grants that encompass the new ideas and the new men which so often constitute the leading and innovative edge in biomedicine. This reduction denies access to these new men and ideas and thus diminishes the scope of scientific thought and enterprise directed toward health problems. It is urgent that this cut be restored.

General Research Support

The general research support program of the NIH is to be cut by more than half-a-million dollars in the Administration's budget. In addition to this absolute cut in dollars, there is a substantial decline in the percentage relationship of GRS funds to funds requested by research grants. In

fiscal year 1969 $60,700,000 was made available for GRS grants which was 8.3 percent of the total research grant funds appropriated. The Administration's budget for fiscal 1973 requests only $54,624,000 for GRS grants which is only 5.7 percent of the total research budget. This is a substantial cutback in the level and role of this important program. The general support for the research and research training programs of medical schools, provides funds which can be used at the discretion of the institutions in the development of new programs, providing initial support for young investigators, undertaking pilot projects and feasibility studies, and supporting centralized facilities and services needed by multiple investigators. These funds thus greatly multiply the value of appropriations specifically directed to the support of research projects. Cutting back this program, which seems to be the Administration's purpose, will substantially impair the effectiveness of the nation's entire medical research structure. We urge appropriations for GRS grants of at least the 1969 level of $60,700,000.

Fellowships and Training Grants

The Administration's proposed 2.2-percent increase in the fellowship and training grant programs of the National Institutes of Health represents a decrease in these programs in real dollars. NIH graduate fellowship and training grant programs constitute the basic national investment in training the young minds and ideas that will shape the future of medical education and research. Only through these programs will new investigators required for such major research efforts as the attack against cancer and heart disease be made available. In a similar manner, the nation's efforts to expand medical education and the training of health personnel is almost completely dependent

upon the additional faculty that will derive from these training efforts. Failure to provide adequate support for these programs can only serve to thwart the other national objectives being sought.

Animal Resources

The general objective of the animal resources program of the NIH Division of Research Resources is to assist institutions in providing the animal resources so vital to biomedical research and education. This assistance has become increasingly important as the costs of humane treatment of laboratory animals have risen under the Animal Welfare Act of 1970. Many institutions find themselves in a phase of accelerated growth, with their existing animal facilities being antiquated, dispersed and inadequate to the task. The use of warm blooded animals as experimental models has amply proven its value in terms of improved health care. Increased federal assistance is essential for the continued humane handling of research animals. One measure of an appropriate increase is the difference between the volume of assistance applications and the amount of actual awards. It is the Association's understanding that in the current fiscal year the volume of applications is more than triple the amount of actual awards. While applications are running at an annual level of about $6 million, actual funding is approximately $1.8 million. The difference is more than $4 million. And this, the Association submits, is the minimum increase that should be approved by Congress over the $1.5 million requested by the Administration for the animal welfare activities of the Division of Research Resources.

It simply is not in the public interest to pursue budget policies the net effect of which is to diminish the level and scope of scientific effort in medicine. Yet this is precisely what is happening as a consequence of the Administration's failure to offset the effect of inflation on the level of research effort.

The President's actions stand in sharp contrast to his words. His 1971 health message said: "...we must reaffirm -- and expand -- the federal commitment to biomedical research." His 1972 health message said: "A truly effective naitonal health strategy requires that a significant share of federal research funds be concentrated on major health threats..."

To reverse the President's actions and to carry out his words will require a fiscal 1973 appropriations level for the NIH Research Institutes and Divisions of $1,960,986,000, an increase of $380.8 million over the request of the Administration. A table is attached at the end of this statement which presents the Association's recommended levels of funding for the NIH research programs in detail. They are carefully considered recommendations, and we respectfully request thoughtful consideration of them.

Other Programs and Activities

There are numerous other programs and activities in the National Institutes of Health and the Health Services and Mental Health Administration which are important agents of change in health. They include NIH assistance in the education of nursing, public health and allied health personnel and operation of the National Library of Medicine. They also include support by the HSMHA of mental health programs, health services planning and development, health services delivery and preventive health services.

The Association of Americal Medical Colleges has commented in this statement on the programs and activities in which it has particular expertise. Other members of the Coalition for Health Funding have similar expertise in many of these other NIH and HSMHA areas. As a member of the Coalition, the Association defers to them, wishes to be associated with them in their remarks, and joins with them in their recommendations for fiscal 1973 appropriations.

One action of the Administration in the budget for the National Institute of Mental Health must be discussed, however, by the Association. That is the planned phasing out of the psychiatric training program. At a time when there is a record demand for mental health personnel in state hospitals, in community mental health centers, and in the fields of childhood mental illness, alcoholism and drug addiction, the Administration's action appears utterly unrealistic. The Administration is attempting to cut graduate psychiatric training by some $7 million and undergraduate psychiatric training by some $5 million. These cutbacks would eliminate about one-third of the psychiatric residencies in the country and seriously undermine undergraduate psychiatric training in virtually every medical school in the nation. It is imperative that these proposed cutbacks be restored. The misleading argument in support of the Administration's proposed reductions -- that government support is wasted on

psychiatrists who then enter private practice -- does not stand up to close examination. Studies show that most psychiatrists enter community mental health systems, academic health centers, or state mental health programs. The Association urges Congress to provide sufficient funds for these programs of psychiatric training to meet the growing demand for mental health personnel so essential to a comprehensive program of health care for the American people.

An action of the Administration in the budget for the Hill-Burton program of medical facilities construction also must be discussed by the Association. The Administration is proposing to cut back drastically the grant support for some types of construction. While the Association is pleased that the Administration is requesting appropriation of the full authorization of $70 million for construction of outpatient facilities, the Association is disturbed that the Administration is not requesting any new funds for modernization of existing hospitals and construction of new hospitals and public health centers. The nation has only begun the task of rebuilding and renewing its hospitals in the context of present-day scientific medicine and health care delivery. The Association recommends that Congress provide sufficient funds to meet the national needs and to carry out the legislatively mandated programs in these areas, in light of the urgent need to renew our obsolete and dilapidated urban hospital facilities.

FUNDS FOR THE NATIONAL INSTITUTES OF HEALTH
(fiscal years)
(in thousands)

	Budget Authority		President's Budget	Authorization or Need	AAMC Recommendation	
	1971	1972[1]	1973	1973	TOTAL	INCREASE
Research Institutes						
Biologics Standards	9,277	9,205	9,528	9,731[2]	9,731	203
National Cancer Institute	233,132	337,670	432,205	532,205	532,205	100,000
National Heart and Lung Institute	194,901	232,168	255,280	337,864[2]	337,864	82,584
National Institute of Dental Research	35,430	43,404	44,415	51,239[2]	51,239	6,824
National Institute of Arthritis and Metabolic Diseases	137,956	153,180	159,089	182,195[2]	182,195	23,106
National Institute of Neurological Diseases and Stroke	103,485	116,609	117,877	145,079[2]	145,079	27,202
National Institute of Allergy and Infectious Diseases	102,337	108,769	112,649	129,742[2]	129,742	17,093
National Institute of General Medical Sciences	160,194	173,513	175,960	204,744[2]	204,744	28,784
National Institute of Child Health and Human Development	94,747	116,916	127,244	188,048[2]	188,048	60,804
National Eye Institute	30,030	37,255	37,384	42,183[2]	42,183	4,799
National Institute of Environmental Health Sciences	20,151	26,436	29,013	33,196[2]	33,196	4,183
Research Resources	66,320	74,948	75,009	100,080[2]	100,080	25,071
John E. Fogarty International Center for Advanced Study in the Health Sciences	3,666	4,288	4,545	4,680[2]	4,680	135
TOTAL RESEARCH	1,191,626	1,434,361	1,580,198	1,960,986[2]	1,960,986	380,788

Footnotes at end of table

FUNDS FOR THE NATIONAL INSTITUTES OF HEALTH
(fiscal years)
(in thousands)

	Budget Authority 1971	Budget Authority 1972[1]	President's Budget 1973	Authorization or Need 1973	AAMC Recommendation TOTAL	AAMC Recommendation INCREASE
HEALTH MANPOWER						
Medical, Dental and related health professions						
a. Institutional support						
(1) Capitation grants						
MOD	32,315	130,000	138,500	213,000*	213,000*	74,500
VOPP	14,485	25,200	27,400	37,000	32,000	4,600
(2) Start-up assistance						
New schools	-----	2,580	2,800	10,000[2]	2,800	--
Converting schools	-----	4,700	5,500	5,500[2]	5,500	--
(3) Special projects	26,873	53,000	53,000	138,000	100,000	47,000
(4) Financial Distress	50,327	20,000	15,000	15,000	15,000	--
(5) Health manpower education initiative awards	-----	20,000	20,000	90,000	75,000	55,000
Subtotal, institutional support	124,000	255,480	262,200	508,500	443,300	181,100
b. Student assistance						
(1) Loans						
United States	24,738	30,000	36,000	55,000	45,000	9,000
Foreign	-----	----	------	1,750	--	--
(2) Scholarships						
United States	15,500	15,500	15,500	28,980[2]	28,980	13,480
Foreign	-----	----	------	150	--	--
Shortage area	-----	----	------	3,000	--	--
(3) Traineeships and fellowships						
Family medicine	-----	5,000	5,000	35,000	5,000	--
Family Practice of Medicine Act[3]	-----	100	------	--	--	--
Health professions teachers	-----	1,000	1,000	15,000	1,000	--
c. Construction						
(1) Grants	131,600	142,385	------	250,000	250,000	250,000
(2) Interest subsidy	-----	800	1,000	16,000	4,000	3,000
d. Computer technology	-----	3,000	3,000	10,000	3,000	--

Footnotes at end of table *Actual appropriation requirements for full level of capitation would total $214.7 million, in contrast to $213 million authorized.

FUNDS FOR THE NATIONAL INSTITUTES OF HEALTH
(fiscal years)
(in thousands)

	Budget Authority 1971	Budget Authority 1972[1]	President's Budget 1973	Authorization or Need 1973	AAMC Recommendation TOTAL	AAMC Recommendation INCREASE
Medical, Dental and related health professions (con't)						
e. Education cost studies	------	2,015	------	------	--	--
f. Postgraduate training of physicians and dentists	------	------	------	7,500	7,500	7,500
g. Educational Grants and Contracts and Direct Operations	4,635	5,061	7,733	7,733[2]	7,733	--
TOTAL, HEALTH PROFESSIONS	300,473	460,341	331,433	938,613	795,513	464,080

FOOTNOTES:

1. Estimate
2. No specific sum authorized. Figure is an estimate of need, based on professional judgment.
3. President Nixon pocket vetoed the Family Practice of Medicine Act on December 26, 1970.

INFORMATION ITEM XIII
PART A

PROJECT ON THE STATUS AND EDUCATION OF WOMEN

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SEX DISCRIMINATION PROVISIONS CONCERNING STUDENTS AND EMPLOYEES AS CONTAINED IN THE HIGHER EDUCATION ACT OF 1972

The Higher Education Act of 1972, effective June 23, 1972, contains provisions which:

1. prohibit sex discrimination in all federally assisted education programs;
2. amend certain portions of the Civil Rights Act of 1964;
3. extend coverage of the Equal Pay Act of 1963 to executive, administrative and professional employees, including all faculty.

I. Sex Discrimination in Federally Assisted Programs Is Prohibited:

A. Basic Provisions: Title IX of the Higher Education Act states:

> "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance...."

These sex discrimination provisions are patterned after Title VI of the Civil Rights Act which forbids discrimination on the basis of race, color, and national origin in all federally assisted programs.[1]

B. Which Institutions Are Covered: All institutions including public and private preschools, elementary and secondary schools, institutions of vocational, professional, undergraduate and graduate education, that receive federal monies by way of a grant, loan or contract (other than a contract of insurance or

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[1] Apart from admission coverage, (see I-C of this paper), the Higher Education Act differs from Title VI in that the sex discrimination prohibition is limited to federally assisted education programs and activities, whereas the race, color and national origin discrimination prohibitions are applicable to all federally assisted programs. Title VI also specifically excludes employment from coverage (except where the primary objective of the federal aid is to provide employment). There is no similar exemption for employment in the sex discrimination provisions relating to federally assisted education programs.

guaranty).[2]

C. Provisions Concerning Admissions to Schools and Colleges:

1. Discrimination in admission is prohibited in:
   a. vocational institutions[3]
   b. institutions of professional education
   c. institutions of graduate higher education
   d. public undergraduate co-educational institutions

This provision goes into effect on June 23, 1973.

2. Exemptions from the admissions provision are as follows:
   a. private undergraduate institutions of higher education
   b. single-sex public undergraduate institutions
   c. elementary and secondary schools other than vocational schools
   d. schools in transition from single-sex to coeducation. Such schools of vocational, professional or graduate education, or public undergraduate education which are about to begin or already have begun the transition to coeducation are exempt from the admissions provision; provided it is carrying out a transitional plan approved by the Commissioner of Education.

NOTE: These exemptions apply to admission only; such institutions are still subject to all anti-discrimination provisions of the Act other than admission.

D. Other Exemptions

1. Religious institutions: institutions controlled by religious organizations are exempt if the application of the anti-discrimination provisions are not consistent with the religious tenets of such organizations.

2. Military Schools: those educational institutions whose primary purpose is the training of individuals for the military services of the United States or the Merchant Marine are exempt.

E. Provision Relating to Living Facilities: The Act allows institutions receiving federal funds to maintain separate living facilities for the different sexes.

F. Who Enforces the Act? The enforcement provisions are identical to those of Title VI of the Civil Rights Act. The federal departments empowered to extend aid to educational institutions have the enforcement responsibility. Reviews can be conducted regardless of whether or not a complaint has been filed.

G. Who Can File Charges? Individuals and organizations can challenge any unlawful discriminatory practice in a federal program or activity by filing with the appropriate federal agency. During the review process, names of complainants are kept confidential if possible.

H. What Happens When a Complaint Is Filed? An investigation is conducted, and if

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[2]Title IV of the Higher Education Act also prohibits lenders who use the Student Loan Marketing Association from discriminating against students on the basis of sex, color, creed or national origin.

[3]This includes vocational high schools.

a violation is found, informal conciliation and persuasion are first used to eliminate the discriminatory practices.

I. Formal Enforcement Procedures: If persuasion fails, the Act provides for formal hearings conducted by the federal agency, which can result in the termination or withholding of federal assistance. In some instances, cases may be referred to the Department of Justice. Recipients of federal monies which have been terminated or withheld can seek judicial review of the final order issued by the agency.

J. Preferential Treatment: Institutions cannot be required to grant "preferential or disparate" treatment to members of one sex when an imbalance exists with respect to the number or percentage of persons of one sex participating in or receiving the benefits of federally assisted educational programs or activities. There are no restrictions in the Act, however, against affirmative action that is non-preferential.

K. Provision Concerning Blind Students: Students cannot be denied admission on the grounds of blindness or severely impaired vision to any federally assisted education program or activity. The institution, however, is not required to provide any special services for such persons.

II. Amendments to the Civil Rights Act of 1964

A. Provisions Relating to Desegregation of Publicly Supported Schools (including elementary and secondary schools and publicly supported institutions of higher education): Title IV of the Civil Rights Act, entitled "Desegregation of Public Education," and which previously applied only to race, color, religion and national origin, is amended to include sex in most of its provisions.

1. Technical Assistance: The Commissioner of Education is empowered to render technical assistance to public institutions preparing, adopting and implementing plans for desegregation.

2. Training Institutes: The Commissioner is authorized, through grants or contracts with institutions of higher learning, to operate short-term or regular session institutes for special training to improve the ability of teachers, supervisors, counselors and other elementary or secondary school personnel to deal effectively with special educational problems occasioned by desegregation.

3. Grants: The Commissioner is authorized to make grants to pay, in whole or in part, for the cost of teacher and other school personnel inservice training in dealing with problems incident to desegregation and employing specialists to advise in problems incident to desegregation.

4. Suits by the Attorney General: Under certain circumstances, the Attorney General is empowered to initiate legal proceedings on behalf of individuals who allege that they have been denied admission to or not permitted to continue in attendance at a publicly supported institution by reason of sex or when the individual alleges that a public institution is depriving him or her of the equal protection of the laws under the 14th Amendment. Title IX of the Civil Rights Act is also amended to extend to cases of sex discrimination the Attorney General's power to intervene, on behalf of the United States, in litigation already begun by others claiming denial of the equal protection of the laws under the 14th Amendment.

III. Extension of the Equal Pay Act of 1963

A. Basic Provisions: Coverage of the Equal Pay Act is extended to executive, administrative, and professional employees.[4] The Act states that women and men performing work in the same establishment under similar conditions must receive the same pay if their jobs require equal skill, effort and responsibility. "Equal" does not mean "identical", but that jobs which are compared under the Equal Pay Act have to be substantially similar.

B. Which Institutions and Employees Are Covered? All employees in all private and public educational institutions at all levels: pre-school, elementary, secondary and institutions of higher education, regardless of whether or not the institution is receiving federal funds.

C. Who Enforces the Act? The Wage and Hour Division of the Employment Standards Administration of the Department of Labor.

D. Compliance Reviews: Reviews can be conducted regardless of whether or not a complaint has been reported. When a review is conducted the entire establishment is checked for compliance.

E. Complaint Procedure: There is no formal procedure for filing a complaint. Complaints may be reported to the nearest Wage and Hour Office of the Department of Labor by letter or telephone. Individuals or organizations may report violations.

F. Anonymity of Complainants: The identity of a complainant is kept in strict confidence by the Department of Labor. Unless court action is ultimately necessary, the name of an aggrieved employee need not be revealed. The same observance of confidentiality is extended to employers (and unions if involved) unless court action is necessary.

G. Power of Enforcement: After investigation, if a violation has been found, the employer is asked to comply with law by raising salaries and awarding back wages to employee(s) who were underpaid. More than 95% of the equal pay investigations are settled without recourse to litigation. Should the employer fail to comply, the Office of the Solicitor of the Department of Labor can bring suit in the appropriate District Court. Individual complainants may also file private suits under the law.

H. Back Pay: When a complaint is held to be valid, employers must raise the salaries of those employees who earned less by reason of their sex, and must compensate employees for the period in which they were being paid less. Generally speaking, the statute of limitations for back pay is two years.

I. Other Provisions: An employer cannot reduce the wage rate of any employee in order to eliminate an illegal wage differential. Labor organizations are also prohibited from causing or attempting to cause an employer to discriminate against an employee in violation of the equal pay provisions.

J. Are Wage Differentials Allowed: The law does not prohibit wage differentials based on a bona fide seniority or merit system, or a system measuring earnings by quantity or quality of production or any factor other than sex.

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[4] Coverage is also extended to outside salespersons.

K. Prevention of Harrassment: Employers are prohibited from discharging or discriminating against any employee who has made a complaint or instituted any proceedings under the Act.

L. Record Keeping: All institutions must keep and preserve records relevant to the determination of whether unlawful practices have been or are being committed. The Secretary of Labor or his designated representatives are empowered to request such information and review the records.

M. Relationship to Other Federal Regulations and Laws Pertaining to Non-Discrimination: Executive Order 11246, as amended, which prohibits federal contractors from discriminating, and Title VII of the Civil Rights Act which was recently amended to cover employees of educational institutions, are still in effect. Employees can file charges simultaneously under all or any of these laws and regulations.

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HEW CONTRACT COMPLIANCE—MAJOR CONCERNS OF INSTITUTIONS

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IN JUNE 1970, the Department of Health, Education, and Welfare, under delegation of authority from the Department of Labor,[1] started actively enforcing its power of conducting contract compliance reviews under Executive Order 11246 as amended by E.O. 11375.

Under the executive order and the implementing regulations of the Department of Labor (41 CFR 60), every institution which holds a Federal contract or subcontract of $10,000 or more must agree not to discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Every private institution which employs more than 50 persons and which holds Federal contracts or subcontracts totalling $50,000 must also have a written affirmative action program on file for each of its establishments. Although public institutions are not required under 41 CFR 60-1-40 to have a written program on file, the obligation not to discriminate and to implement an affirmative action program does apply. HEW takes the position that a public institution can best carry out this obligation by conducting the same kinds of analyses required of nonpublic institutions by organizing into a written program its plans to overcome problems of past discrimination and underutilization.

Colleges and universities, at first individually and then—in January 1971—collectively, have tried to work with HEW and its regional offices to adjust whatever policies and practices on their campuses may have led to racial and sex discrimination. University and college administrators as well as campus and national women's groups have raised various issues that need resolution if discrimination is to be elimina-

1. The Department of Labor has overall policy responsibility for administering the executive order; HEW is the monitoring and investigating agency for institutions holding Federal contracts.

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ted.[2] On some issues the women's groups side with HEW; on other issues they join institutions in criticizing HEW actions and policies. Despite nearly two years of effort, institutions still have little guidance in approaching and resolving the issues that relate to contract compliance.

It is now possible, however, to describe a typical contract compliance review in general terms of how it may currently be conducted. The material in the section immediately following is based on information gained during the past year; specifically, it draws on the experiences of the women's groups, of individual institutions, committee and staff work in the American Council on Education, and the Project on the Status and Education of Women of the Association of American Colleges.

The description of a contract compliance review leads, in turn, to the identification of nine major issues that, at the time of this writing, still remain unresolved. These are discussed in succeeding sections.

The Compliance Review

Typically, a complaint against an institution holding a contract with the Federal Government is filed with the Secretary of Health, Education, and Welfare, who refers it to one of the ten HEW regional offices. At first, HEW gave priority to individual complaints; now, however, priority has shifted to pattern complaints and to preaward compliance reviews (contracts involving more than $1 million cannot be awarded without a prior investigation regarding nondiscrimination and adequacy of the affirmative action program).

The scheduling of a compliance investigative review depends on several factors, including the work load of the regional office. Each regional office issues its schedule of reviews quarterly, but in actuality a review is often delayed, sometimes with very little notice.

A letter goes to an institution notifying it that it is scheduled to be investigated by an HEW contract compliance review team, and requesting various kinds of information to be assembled in advance of the review. Institutions are often surprised by the scheduling of the investigation and unaware of the procedures that will be followed. They may also be unprepared to provide the information requested because HEW has not yet specified what information it will require in all reviews and the type of information requested in past reviews has varied from campus to campus. At the present writing, HEW is in the process of drafting a memorandum to presidents of institutions to inform them of the procedures involved in a review and has begun to codify the kinds of information it will require in all campus investigations. It appears that institutions are likely to be asked for the following:

1. A listing of all employees (academic and nonacademic, full time and part time, permanent and temporary, and students employed by both academic and nonacademic units). The inventory must list employees by race, sex, and ethnic origin, with job category, rate of pay, status (full time or part time, tenure, permanent or temporary, etc.), number of hours if working part time, date of hire, date of last promotion, and age.
2. A copy of any program (written affirmative action plan) which details actions being taken to guarantee equal employment, along with any written analysis or evaluation of the program.
3. A listing of all persons hired (except in labor service categories) in a recent period (usually six months or a year depending upon circumstances), identifying job or position classification, date of hire, starting pay rate, race or ethnic origin, and sex.
4. Copies of tests and other criteria used in making selections for employment, upgrading, and promotion; copies of any validation studies of the criteria.
5. Copies of manuals or other materials that describe matters affecting the employment or treatment of employees, such as faculty manuals, administrative practice manuals, personnel procedures, and operating guides.

In addition, investigators may request other information that they view as pertinent. Sometimes, when investigators have conferred with women or minority groups on the campus, these groups have suggested particular areas for investigation. For example, the HEW team may ask to see the personnel files of a specific department or other organizational unit, examining in greater detail the individual records of women and men applicants and employees. Department heads or supervisors, as well as some selected employees, may be interviewed. The review process may be completed in a scant three weeks or it may last for months.

When the investigation is completed, HEW, through

[2]Among these groups are women's civil rights groups such as Women's Equity Action League (WEAL) and the National Organization for Women (NOW); campus women's groups such as FOCUS at the University of Michigan, League of Academic Women (LAW) at the University of California, Berkeley; caucuses within the professional disciplines such as American Historical Association, Modern Language Association, American Political Science Association, etc.

Although this paper puts forth some of the views of women's groups, the reader should bear in mind that the executive order prohibits discrimination on the grounds of race, color, religion, and national origin as well as sex.

its regional office, gives the institution a "letter of findings" which details the results of the investigation and is usually presented to the institution's head during an "exit conference." The administrator may take exception to any or all of the findings provided he or she can supply supporting data. In any event, within 30 days after date of the letter of findings, the institution must make a written commitment to correct "deficiencies" noted in the findings and submit a written plan for doing so. The plan is then reviewed by the regional and Washington offices. The letter of findings is kept confidential by HEW, although the institution is free to make its contents public. In many cases, the delay between the issuance of the letter of findings and HEW's acceptance of an affirmative action plan has extended to over a year.

At any point during the compliance review, either before or after the letter of findings, HEW can delay awarding of a new contract, should it find that the institution is in noncompliance and that reasonable efforts to secure compliance by conciliation and conference are not working. Such delay is often for a specific number of days, within which the institution must move into compliance if it wants new contracts. The procedure for delay of a *new* contract is fairly informal; in contrast, the procedure for the termination or suspension of an *existing* contract is far more formal, involving a hearing before the sanction is imposed.

Issues in Compliance Review Processes

For over a year, administrators throughout the country have voiced concern about various actions and policies of HEW. The following major issues have been raised by college and university officials with sufficient frequency to warrant detailed analysis:

1. Lack of uniform action by regional offices
2. Need for Federal guidelines
3. Access to personnel files
4. Due process of law in compliance reviews
5. Time requirements for response
6. Status of retroactive pay under Executive Order 11246, as amended
7. Publication of affirmative action programs
8. Criteria for measuring discrimination
9. Graduate admissions

1. *Lack of Uniform Action by Regional Offices*

The conduct of contract compliance reviews by the U.S. Department of Health, Education, and Welfare is a relatively new function for that agency. Probably as a result, actions taken by the various regional offices have often been found to be inconsistent, and agreements acceptable in one region of the country may be unacceptable in other regions. Many regional HEW personnel seem to lack a clear understanding both of the existing guidelines and regulations and of the university community. Women's groups also claim that some HEW personnel are often unaware of the regulations they are to enforce. The Women's Equity Action League (WEAL), which has been particularly active in filing charges of sex discrimination, has called for a congressional investigation of HEW's handling of the sex discrimination complaints. It is suggested that if fairness to women and to institutions is to be achieved, regional HEW personnel must be informed of, and trained in, HEW procedures and their own responsibilities. It may also serve the best interest of all parties if HEW officials become better acquainted with the problems and processes of academic administration.

2. *Need for Federal Guidelines*

Although Executive Order 11246 has been in effect since 1965 and the sex discrimination provisions (Executive Order 11375) since 1968, HEW has not yet notified the academic community how it is to implement the provisions of the executive order and its regulations. Institutions and women's groups need to know what procedures are employed by HEW in enforcing the executive order, and also what information is required from the institutions and the form it should take—to cite only two of the several procedural matters that need resolution.

The Department of Labor has issued guidelines and policy statements concerning the executive order on nondiscrimination, but some issues that relate specifically to institutions of higher learning cannot readily be resolved by a reading of the regulations. In HEW, the lack of guidelines for institutions and the lack of consistent procedural regulations for HEW employees have caused major difficulties in seeking conciliation among HEW, institutions, and women's groups.

In summary, HEW guidelines for institutions of higher education are needed to serve as notice and guide as well as to ensure uniformity of action by HEW regional offices.

3. *Access to Personnel Files*

Institutions have recently raised the critical issue of whether HEW has the right to inspect all personnel files that it deems pertinent to a contract compliance review.

HEW maintains that its power to inspect university personnel records is derived from the "equal opportunity clause" of Executive Order No. 11246, as amended

(Pt. II, subpt. B, Sec. 202 [5]), which is embodied in all university contracts with the Federal Government. Regulations permit access to "books, records, and accounts pertinent to compliance" for "purposes of investigation to ascertain compliance with the equal opportunity clause of the contract . . ." (41 CFR Sec. 60-1.43). (Other antidiscrimination legislation also requires that employers make this information available.) Although the contractor agrees in writing to furnish required information and reports, and to comply with orders and regulations implementing the executive order, the extent of HEW's power to examine personnel files is questioned by institutions.

On the basis of these regulations, HEW has asked institutions for personnel records that relate to employment in order to evaluate whether or not discrimination exists. Institutions have been concerned about the possible disclosure of such information to unauthorized persons who do not have a legitimate interest in the content of personnel files.

Institutions contend that there are countervailing personal privileges and rights, including those of constitutional dimension, that compel a limitation of HEW's right of inquiry. A relationship of trust and confidence between faculty and administration, which is essential to the operation of a university, may be jeopardized and perhaps destroyed by improper disclosure of personnel records. Specifically, it is argued that in order to select and promote faculty, it is imperative to obtain candid appraisals, by individuals within and without the institution, of the qualifications of candidates without inducing fear in the recommender that his or her confidence may be breached. In view of the institution's particular concern for the right of its members to speak freely, the maintenance of confidentiality of personnel files to some has become inextricably interwoven with the very maintenance of academic freedom. Moreover, administrators contend that examination of selected personnel files by HEW in the absence of a persuasive showing of cause constitutes a serious invasion of the right of privacy of the faculty member involved.

On the other hand, HEW employees are prohibited by the Freedom of Information Act from disclosing information contained in personnel files. The act specifically exempts from disclosure "investigatory files compiled for law enforcement purposes except to the extent available by law to a party other than an agency."

On this issue the women's groups agree with HEW. They point out that if employment records are not available to HEW, then both HEW and the institution will be vulnerable to the charge of an incomplete and unfair investigation. The women ask how discrimination or the lack of discrimination can be evaluated if employment records are not available to HEW personnel. It is of interest to note here that the women's groups are not asking that personnel records be disclosed, only that they be made available to HEW personnel.

HEW has proposed but not yet issued a statement clarifying its policies concerning confidentiality of records.

4. *Due Process of Law in Compliance Reviews*

Numerous issues involving the implementation of due process of law with regard to compliance review have been raised by administrators.

a) Notice of Impending Review—HEW's practice is to have the appropriate regional office give written notice to the head of the institution three to four weeks before a compliance review is scheduled to begin. Institutions maintain that since punitive sanctions may be invoked, notification of the impending review should be given as far in advance as possible so that the institution may be adequately prepared for such review. It is suggested, for example, that as soon as HEW issues its quarterly schedule of reviews, all institutions listed should be notified immediately.

Women's groups and individual complainants have also expressed concern about HEW's notification procedures, claiming that they have rarely been notified of impending reviews and therefore have not been able to supply additional information to HEW.

b) Notice of Complaint—Currently, when complaints are filed with HEW, no notification is given to institutions until a compliance review is scheduled. In some instances the interval between filing of charges and the scheduling of a review has been a year or longer. Furthermore, some schools complain that HEW officials fail to spell out charges with sufficient specificity. An institution therefore lacks adequate data upon which to formulate or evaluate its program. If universities and colleges are to begin to study their policies and practices, it is critical that notification that charges have been filed be furnished in sufficient detail within a reasonable period of time, regardless of the date of the compliance review.

It would also be helpful if HEW would send copies of all pattern complaints to institutions promptly. Any procedures adopted would, of course, have to contain provisions safeguarding individual complainants from harassment.

c) Right to a Hearing—Federal regulations provide that "no order for cancellation . . . termination . . . or for debarment from further contracts or subcontracts . . .

shall be made without affording the prime contractor or subcontractor an opportunity for a hearing" (41 CFR Sec. 60-1.26 [b] [2]).

The problem area for institutions relates to the delay in awarding of *new* contracts. Any contract can be held up where a question exists about whether an institution is in compliance. As noted earlier, every contract in excess of $1 million must have a preaward review to certify that the institution is in compliance with Executive Order 11246 (41 CFR Sec. 60-1 20 [d]). HEW maintains that the Government has the right to fix the terms and conditions of contracts awarded, a right which has been upheld by the courts. HEW claims that if a contract has not been officially awarded, the fact that it is "held up" does not constitute a deprivation of property without due process of law, which would require the granting of a hearing. Institutions argue that the foregoing constitutes a distinction without a difference and that inasmuch as the contract has been granted (though not completely cleared), any interference with their rights under the contract should be preceded by notice and a hearing.

d) Right of Appeal—HEW claims that the regulatory process as now constituted provides an opportunity for institutions to appeal decisions by a regional office to the national office. A "right of appeal" that is not set out in writing is not a right but a privilege that may be granted at administrative discretion. A written guarantee of appeal would help ensure that national guidelines are followed in a reasonably consistent manner. An established process of appeal would also eliminate confusion on the part of institutional authorities following exit conferences, by prescribing the next step for resolution of differences arising out of the findings made by the compliance review team. Women's groups have also complained about the lack of appeal procedures for complainants.

e) Presumption of Innocence—Administrators state that the HEW attitude seems to be that all colleges and universities are guilty of discrimination against women. Thus, institutions feel that they are having to sustain the burden of proof that they are not discriminating. HEW's position seems to be that an individual complaint does not have to set out a *prima facie* case, but must merely meet the burden of "going forward." Once the individual has produced sufficient evidence to support the legitimacy of his or her complaint, the burden of "going forward" shifts to the institution, not as a penalty, but because it alone possesses the information necessary to substantiate or refute the charges that have been brought. Both administrators and HEW regional officers have interpreted this shift in the burden of "going forward" as being equivalent to a change in the Anglo-American system of jurisprudence by making an individual guilty until proven innocent.

HEW's Washington office contends that since the Government's right to set the terms of its own contracts was upheld in the courts, the institution, if it wants the contract, must meet the terms of the contract, i.e., nondiscrimination, and show that it has done so. There is no presumption of either innocence or guilt.

f) Right to a Timely Decision—In many cases, an institution has filed an affirmative action plan with HEW and has not been notified, sometimes for months, of its acceptability. During the waiting period it remains uncertain whether or not it is in compliance. According to HEW, an institution is not in compliance until approval of the plan is formally communicated. Any institution that has filed an affirmative action plan should be notified in a timely manner of the plan's current status so that it may rectify any deficiencies at the earliest possible time. Women's groups have been equally critical of such delays.

5. *Time Requirements for Response*

Institutions argue that some of the time limitations embodied in the regulations pertaining to the Executive Order 11246 are unreasonable. A particularly bothersome requirement is encountered in instances where the head of an institution, following an exit conference, takes exception to any one of the findings made by the compliance review team. Under the requirement, he or she may defer commitment on that specific finding provided detailed facts are forwarded to support the exception not later than 7 days after the conference and provided the institution makes an adequate commitment to correct all other deficiencies to which the contractor does not take exception.

Institutions have also had substantial difficulty in meeting the requirement which provides that within 30 days following the exit conference, they are to prepare a detailed program of specific actions to be taken within a stated period of time to remedy specific problems or deficiencies identified as a result of the compliance review.

HEW officials have indicated willingness to grant extensions if an institution cannot meet deadlines, and in practice it has done so. Institutions want HEW to declare a policy of granting extensions of time requirements when their strict implementation would constitute a severe burden to the institution. Women's groups have routinely complained when HEW has allowed any delays beyond the time limits set out in the regulations, charging that continual requests for extensions show bad faith by the institution.

6. *Status of Retroactive Pay under Executive Order 11246*

Several institutions and women's civil rights groups have researched the question of whether the executive order vests HEW with legal authority to compel the payment of retroactive pay to compensate individuals for losses resulting from discrimination in employment practices.

David Frohnmayer, legal assistant to President Robert D. Clark of the University of Oregon, made a detailed analysis of the retroactive pay requirement, and in a July 16 memorandum to the chief counsel for the Oregon State Board of Higher Education reported his conclusion "... that HEW has no legal authority to make such a demand for retroactive pay." Mr. Frohnmayer examined in detail the several points which HEW had been using in citing its legal authority to demand retroactive pay. In criticizing the HEW argument, Mr. Frohnmayer pointed out that "HEW concedes that the executive orders contain no provisions for such a back pay requirement, *and* Title VII cases on the point of back pay are *not* directly applicable to discrimination in violation of the Executive Orders."

HEW argues, however, that "numerous discrimination cases brought under *other provisions* of the law have held that employment discrimination *must* be remedied by the payment of lost wages...." Further, in two recent cases, the U.S. Court of Claims, citing another executive order dealing with discrimination, granted back pay to the plaintiff Federal employees. Counsel for several institutions see the two cases as clearly distinguishable from any similar situation arising at colleges and universities and believe them to constitute no precedent.

Attorneys for women's civil rights groups disagree, and support HEW on the legality of back pay, pointing out that the courts have long upheld back pay in cases of discrimination brought under various remedies such as the Civil Rights Act (Title VII),[3] the Equal Pay Act, the Fourteenth Amendment, and other executive orders dealing with discrimination. Like the executive order that applies to universities and colleges, none of these remedies specifies back pay in its wording; yet this has not prevented the courts from upholding the applicability of back pay. Moreover, the women's groups add, the principle of redress of individual grievances is well established in law. Women's groups do not view back pay as a sanction but as compliance with the terms of Federal contracts previously entered into. They add that, should redress of inequities not be retroactive, then institutions would be vulnerable to suits for violation of the terms of Federal contracts held during the time when the inequities occurred, and liable for repayment of contract money to the government. The civil rights attorneys claim that if back pay is not forthcoming, institutions may expect women to file a rash of large individual suits for damages incurred.

Institutions have noted that imposition of a back pay requirement may constitute an intolerable financial burden. They argue that retroactive pay should not be awarded because HEW has no authority to award such damages, and that since the promulgation of Executive Order 11246, as amended, institutions have had insufficient information upon which to establish an affirmative action program in order to have been in compliance.

Women's groups and HEW counter that the Federal contracts that institutions have signed have included the nondiscrimination provisions, and that the executive order itself specifically mentions discrimination in rates of pay as being prohibited.

7. *Publication of Affirmative Action Programs*

HEW would like to incorporate a provision in the national guidelines which would require an institution to make its affirmative action plan public within a reasonable time after the exit conference. The Department of Labor has ruled, however, that affirmative action plans are exempt from disclosure under the Freedom of Information Act (5 USC 552 [b] [4]) because they contain "commercial or financial information obtained from a person and [are] privileged or confidential." Therefore, the government need not release their plans, although the institutions are free to do so at their own discretion.

Affirmative action plans are general statements of policy and practices and do not contain any financial or commercial information, and an institution is in no way harmed if its plan falls into the hands of another college or university. Good personnel practices dictate that employee personnel policies having the broad nature of affirmative action plans should be made available to the people they are supposed to benefit, and many institutions have indeed followed this practice by making their affirmative action plans public. Women and minorities claim that they cannot fully evaluate any affirmative action plan for their benefit if they do not know what its contents are, nor can they judge the effectiveness of its implementation.

The Department of Labor takes the position that letters of findings and the institution's response are

3. The recently enacted law amending Title VII, which extends coverage to colleges and universities, provides that back pay may be awarded for up to two years prior to the date the complaint is filed.

confidential and unavailable to the public under the Freedom of Information Act as "investigatory files compiled for law enforcement purposes" (5 USC Sec. 553, 45 CFR Sec. 577).

The Labor Department authorizes the Office for Civil Rights in HEW to withhold letters of findings and replies of contractors while negotiations are in process. Some women's groups claim, however, that once negotiations are concluded, the Freedom of Information Act and the regulations implementing the executive order require public disclosure of the letter of findings, the institution's responses, and any resultant affirmative action program. Information such as salaries and personal information which the institution provides to HEW under an express or implied promise of confidentiality is, according to HEW, permanently immune from required disclosure.

8. *Criteria for Measuring Discrimination*

The Department of Labor published, on December 4, 1971, Revised Order No. 4, which details affirmative action requirements for contractors. The most important additions in the order are requirements that employers analyze their work force to determine whether women are being underutilized and, where deficiencies are found, develop goals and timetables for remedying the situation. Contractors and subcontractors continue to be required to make "good faith" efforts to correct deficiencies in the utilization of women "at all levels and in all segments" of their work force. As under the earlier version of the order, failure to correct the underutilization of women through development and implementation of an acceptable affirmative action program can lead to cancellation of existing contracts and subcontracts as well as debarment from future contracts and subcontracts.

The factors that contractors must consider to determine whether women are being underutilized in any job classification are based on general labor concepts and practices. The criteria are: amount of female unemployment in the labor area surrounding the facility; the female proportion of the total work force in the immediate labor area and an area in which the contractor can reasonably recruit; the availability of women seeking employment in the labor or recruitment area of the contractor; the availability of promotable and transferable female employees within the contractor's organization; the existence of training institutions capable of upgrading persons with the requisite skills, and the degree of training which the contractor is reasonably able to undertake as a means of making all job classes available to women.

Although the order does not define "immediate labor area," the Department of Labor and HEW have interpreted the term as varying with the class of job: the immediate labor area for clerical help would probably be local; for academic and professional personnel, the labor market is national. Thus, the area of recruiting is different for the different levels and types of jobs. HEW will *not* set up criteria to be used for hiring or promotion, rightly stating that for it to do so would indeed be an infringement of academic freedom. Under executive order, HEW claims that each institution should specify its own job-related criteria for hiring and that these criteria, whatever they are, should apply equally to women and to men, to minorities and to nonminorities. Part of the difficulty that has arisen in the academic community is that these criteria have not always been specified or have varied with each person hired or promoted in a department; for example, lack of publication may be held as a reason individual X was not promoted although individual Y, who did not publish, was promoted, etc.

Institutions claim that the general criteria prepared for other labor markets pertaining to underutilization do not take cognizance of the special characteristics of the academic labor market—heavy dependence on the specific qualifications of individuals rather than on job specifications; the specialized training and education required for faculty positions; recruitment through institutions and processes markedly different from those characterizing industrial recruitment. Women's groups disagree, stating that the enumerated criteria are sufficiently general to apply to *all* hiring processes.

HEW regional offices have relied heavily on statistics to disclose the national proportion of women and minorities who have formal qualifications for academic positions. HEW and women's groups feel that such statistics indicate an estimate of the pool of qualified and available people; institutions strongly disagree and state that even more refined statistics would not provide information of markedly increased validity.

There remains the question of assessing the net result of the employer's actions. Have these actions resulted in a nondiscriminatory situation with respect to recruitment, hiring, promotions, transfers, and dismissals? How is good faith assessed? If institutions feel that statistics are not the answer, other answers must be found. A search for objective measures of good faith should supplement the search for statistical equity as the measure of efforts to attain equity in employment opportunities. HEW should detail how nondiscrimination is to be assessed in the academic setting, the possibilities and limitations of "statistical equity," and means, in addition to statistical measures, for assessing and delineating good faith efforts.

In considering the means of assessing nondiscrimination, it must be pointed out that neither the executive orders nor HEW has the intent of forcing the employer to hire unqualified persons, although HEW's policy has often been misinterpreted by institutions of higher education and HEW personnel alike.

Under Revised Order No. 4, numerical goals are a starting point in determining good faith compliance. Goals are numerical targets which a contractor tries to achieve. Their aim is affirmative in intent: to help increase the number of qualified minority people, including women, in the organization. They are flexible, and failure to meet a goal does not automatically indicate noncompliance *provided good faith efforts have been made to meet the goals.* If contractors meet their goals, it is reasonable to assume that they are in compliance, but the obligation to meet the goal is *not* absolute.

Goals differ from quotas in a number of ways. Quotas are fixed numerical limits that have the discriminatory intent of restricting the participation of a specified group in a particular activity.

The concept of numerical target goals as a legitimate requirement for Federal contractors was upheld by the Supreme Court in October 1971. Because much academic recruiting is national, universities and colleges will be considering the national pool of available women and minorities as each institution sets its own numerical goals. HEW should compile the data relating to the national pool and make it available to the academic community.

9. *Graduate Admissions*

The question has been raised whether an institution's graduate admissions are subject to review under the provisions of Executive Order 11246. Women leaders have maintained that the order grants jurisdiction over admissions to graduate study. They contend that admission to graduate school is akin to entry into the apprenticeship program of a labor union and that failure to gain admission effectively curtails one's chances of securing faculty employment at a later date.

Although HEW does not accept the apprenticeship concept, it indicated it may assert jurisdiction where a relationship can be demonstrated between admission to graduate school and employment in the institution, such as in a teaching or research capacity. Institutions have contended that Executive Order 11246, as amended, does not grant HEW authority to review admission to graduate school and have for the most part declined to supply information regarding graduate admissions procedures. Policy in this area is still unsettled; HEW has not pressed this issue and is currently awaiting developments with regard to the sex discrimination provision in the higher education bill of 1971 (S. 659) in order to determine what future action may be required.

Federal involvement in ensuring nondiscrimination at institutions of higher education is likely to expand over the next several years. Women and other minority groups are examining academic policies and procedures for their impact and are pressing for change. Many institutions have begun to reevaluate their practices not only because of threatened government sanctions, but because of an increasing awareness that inequities exist and that these disparities should be corrected if the benefits of the educational system are to be available to all.

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INFORMATION ITEM XIV

FACULTY UNIONIZATION - RECENT DEVELOPMENTS

15 SEPT 72.

Collective bargaining as a means of coordinating faculty action has continued to gain momentum over the past year. The American Association of University Professors (AAUP), at its annual meeting in the Spring, voted overwhelmingly (373 to 54) to endorse a recommendation of the AAUP policy-making council to "pursue collective bargaining as a major additional way of realizing the Association's goals." The National Education Association (NEA), traditionally dominated by elementary and secondary school teachers, voted at its annual convention in July to make union organizing on college campuses an "NEA priority." The Chronicle of Higher Education reported on May 15, 1972, that a total of 254 institutions of higher education have faculties which are now represented by collective bargaining agents. (List attached)

The process of collective bargaining in the academic setting is governed by the same legal standards and procedures as govern labor-management relations generally: Federal law administered by the National Labor Relations Board (NLRB) in the case of private institutions (with gross annual revenues in excess of one million dollars), and in the case of public institutions, state law administered by state labor relations boards where these exist. In the absence of state legislation governing collective bargaining by public employees, unionization at public institutions is unregulated and the status of bargaining agents is dependent upon the willingness of the governing boards of the institution (the employer) to grant them recognition (i.e. to negotiate with them).

In general the steps in the process of collective bargaining are as follows:

A. Organizing Activity. Organizations seeking to represent the employees of a particular group or category (a "unit") conduct a campaign to elicit the interest and commitment of the employees. Authorization or designation cards are distributed and collected.

B. Request for Recognition. If the employer and the employee organization agree as to the configuration of the bargaining unit, and the organization can demonstrate that it has more than majority support from the employees in the unit, the employer is free to recognize the organization as the employees' agent for collective bargaining purposes.

Unit determination requires the resolution of such questions as: Should the unit include all professional employees or only the teaching faculty? ...all colleges of the university or only specified schools? Should it include or exclude department chairmen? The general principle is that the unit should include all of the employees who share in a common community of interests.

The operation of this principle in a particular situation depends on the facts of the case. The factors considered by the NLRB in determining the appropriateness of the bargaining unit in the Fordham University case, where the issue was the inclusion or exclusion of the faculty of the law school, were:

1. The separate building in which educational programs are conducted;
2. The exclusivity of use of that facility;
3. The lack of interdisciplinary involvement among the other schools of the university by the faculty of that professional school;
4. The percentage of faculty members holding full professor ranks in the professional schools as compared with the rest of the university;
5. The more rapid rate of acquiring tenure in the professional school as compared with the university;
6. The average salary scale employed in the professional school as compared to the university;
7. The market place which is used for comparison and competition for determining prevailing faculty salary rates in the professional schools;
8. The prerequisite of degree requirements for faculty status at that professional school;
9. The regulation of the course of curriculum and class scheduling in the professional school by outside agencies;
10. Teacher work load as compared with the rest of the university;
11. Unique operation within the context of the professional school;
12. Unique calendar and examination date;
13. Prior bargaining history;
14. Preferences of the faculty within the proposed unit.

The designation cards are used for the purpose of demonstrating the organization's support. The employer and the organization may agree upon a procedure for proving majority status such as submitting employee lists and the preference cards to some neutral third party for counting and comparison. Again, no public institution in a state without enabling legislation is under any compulsion to recognize any employee representative for collective bargaining purposes.

C. Filing for Certification. If the employer refuses to recognize the organization as the employees' agent, or the parties cannot agree on a unit determination, the organization may file a petition for certification with the NLRB or the state labor relations board. Generally, this requires approximately a 30% showing of interest from the employees of the potential unit. The board will hold hearings and resolve the issues between the parties. It may find it appropriate to certify the organization as the employees' agent or it may order an election.

D. Election of the Agent. Once the unit has been determined, if the parties agree to an election or one is ordered by the board, this becomes the next step in the process. Requirements for competing organizations to gain a place on the ballot vary. Some states require a showing of interest of 30%, some 10%, of the employees. In some, one designation card is sufficient. The NLRB will allow an organization on the ballot without any additional showing if it already represents a similar segment of employees in the same industry. In the election the choice is between any agent appearing on the ballot and "no agent." Victory in the election requires majority support from those voting; runoff elections may be required.

E. Certification. The organization receiving a majority vote is certified as the bargaining agent for the unit, normally the exclusive bargaining agent. This means that the employer is precluded from negotiating with any other agent and is required to negotiate in good faith with the certified agent. Failure to comply with these restrictions constitutes an "unfair labor practice."

F. Negotiation of a Contract. The agent and the employer may now negotiate a contract governing the terms and conditions of employment of all employees within the bargaining unit (whether or not they are members of the agent's organization). Both must bargain in good faith, neither may discriminate in favor or against a member or non-member of the union. They need not reach agreement, but neither may they refuse to bargain.

G. The Contract once signed governs the terms and conditions of employment of all employees in the unit. It also governs relations between the employer and the agent for the duration of the contract, to the extent the agreement is not inconsistent with the applicable law governing their relations generally.

The chart which follows indicates the status of collective bargaining activity at universities with medical colleges.

STATUS OF COLLECTIVE BARGAINING ACTIVITY AT UNIVERSITIES WITH MEDICAL COLLEGES

School	Organizing Activity	Unit Determination	Agent Elected	Contract Negotiate
State University of New York		All academic and non-academic professional employees; all campuses; includes medical faculty; includes dept. chairmen.	Senate Profession Association, affiliate of NEA	For Period July 1, 1971 t June 30, 1974
Wayne State University, Michigan		All teaching faculty; includes medical faculty; excludes dept. chairmen in five colleges including medical college.	AAUP	Negotiations underway
College of Medicine and Dentistry of New Jersey		Rutgers Medical School and New Jersey Medical School have separate bargaining units	AAUP local chapters represent each unit.	Negotiations in the Fall of 1973
University of Hawaii		Single state-wide bargaining unit set by legislation includes medical faculty.	Scheduled for Fall 1972; on ballot: AAUP, AFT NEA & Hawaii Govt.	Employees Ass
Michigan State University	X	Includes Medical Faculty	Election in the Fall of 1972; choice is NEA affiliate or no agent.	No Contract
University of Wisconsin	50% show of interest; includes medical faculty; enabling legislation anticipated; AAUP expects to be the agent			
University of Nebraska	Enabling legislation recently enacted.	Not determined; AFT seeking to represent Omaha campus; AAUP seeking to represent Lincoln campus. Univ. seeking single bargaining unit.		

STATUS OF COLLECTIVE BARGAINING ACTIVITY AT UNIVERSITIES WITH MEDICAL COLLEGES

School	Organizing Activity	Unit Determination	Agent Elected	Contract Negotiate
University of Illinois	Organizing activity in anticipation of enabling legislation; Board of Regents has not recognized previously elected agents.			
Mt. Sinai		Medical faculty paid by City U. of New York are members of CUNY bargaining unit; this is small fraction of Mt. Sinai faculty.	Agent affiliated with both NEA and AFT.	Yes
Univ. of California	No enabling legislation; legislative study commission is expected to report this at next session with recommendation favoring such a statute.			
University of Minnesota	Legislation has been enacted; no organizing activity to date.			
Temple University	X	Medical faculty was excluded from bargaining unit by Pa. Labor Relations Board.		
New York University		Before the NLRB		

Colleges and Universities Where Faculties Have Chosen Collective Bargaining Agents

Following are 254 institutions of higher education where faculty members have named agents to represent them in collective bargaining. Numbers in parentheses following the names of multi-campus systems indicate the number of institutions in those systems.

NATIONAL EDUCATION ASSOCIATION

Four-Year Institutions

Central Michigan U
City U of New York (19) (with AFT)
Detroit C of Business, Mich.
Fitchburg St C, Mass.
Monmouth C, N.J.
Nebraska St C System (4)
New Jersey St C System (6)
Pennsylvania St C and U System (14)
Saginaw Valley C, Mich.
Salem St C, Mass.
State U of New York (26)

Two-Year Institutions

Adirondack C C, N.Y.
Alpena C C, Mich.
Arapahoe C C, Colo.
Atlantic C C, N.J.
Auburn C C, N.Y.
Bergen C C, N.J.
Big Bend C C, Wash.
Broome C C, N.Y.
Burlington Cnty C, N.J.
Camden Cnty C, N.J.
Centralia C, Wash.
Clinton C C, N.Y.
Cloud Cnty C J C, Kan.
Columbia Basin C C, Wash.
College of Lake Cnty, Ill.
Cumberland Cnty C, N.J.
Dutchess C C, N.Y. (with AFT)
Edmonds C C, Wash.
Erie C C, N.Y.
Essex Cnty C, N.J.
Ft. Steilacoom C C, Wash.
Fox Valley Tech Inst, Wis.
Fulton-Montgomery C C, N.Y.
Garden City C J C, Kan.
Genesee C C, Mich.
Genesee C C, N.Y.
Glen Oaks C C, Mich.
Gloucester Cnty C, N.J.
Gogebic C C, Mich.
Grays Harbor C, Wash.
Green River C C, Wash.
Highline C C, Wash.
Hudson Valley C C, N.Y.
Hutchinson C J C, Kan.
Independence C J C, Kan.
Jackson C C, Mich.
Jamestown C C, N.Y.
Jefferson C C, N.Y.
Kalamazoo Valley C C, Mich.
Kansas City C J C, Kan.
Kellogg C C, Mich.
Kenosha-Racine Tech Inst, Wis.
Labette C J C, Kan.
Lake Land, Ill.
Lake Shore Tech Inst, Wis.
Lansing C C, Mich.
Lehigh Cnty C C, Pa.
Lowe Columbia C, Wash.
Luzerne Cnty C C, Pa.
Massasoit C C, Mass.
Mercer Cnty C C, N.J.
Mid-Michigan C C, Mich.
Mid-State Tech. Inst, Wis.
Minnesota St J C System (18)
Mohawk Valley C C, N.Y.
Moraine Park Tech Inst, Wis.
Monroe C C, N.Y.
Monroe Cnty C C, Mich.
Montcalm C C, Mich.
Mt. Wachusett C C, Mass.
Muskegon C C, Mich.
North Country C C, N.Y.
North Central Tech Inst, Wis.
Oakland C C, Mich.
Ocean Cnty C, N.J.
Olympic C, Wash.
Orange Cnty C C, N.Y.
Peninsula C, Wash.
Rhode Island J C
St. Clair Cty C C, Mich.
Sauk Valley C, Ill.
Schenectady Cnty C C, N.Y.
Schoolcraft C, Mich.
Shoreline C C, Wash.
Skagit Valley C, Wash.
Somerset Cnty C, N.J.
Southwestern Michigan C
Spokane C C, Wash.
Suffolk Cnty C C, N.Y.
Ulster Cnty C C, N.Y.
Walla Walla C C, Wash.
Washtenaw C C, Mich.
Waukeshaw Cnty Tech Inst. Wis.
Wenatchee Valley C, Wash.
Williamsport Area C C, Pa.
Yakima Valley C, Wash.

AMERICAN FEDERATION OF TEACHERS (AFL-CIO)

Four-Year Institutions

Boston St C, Mass.
Bryant C, R.I.
City U of N Y (19) (with NEA)
Layton Sch of Art and Des, Wis.
Long Island U, Brooklyn Center, N.Y.
Long Island U, C.W. Post Center, N.Y.
Lowell St C, Mass.
Massachusetts C of Art
Moore C of Art, Pa.
Pratt Inst, N.Y.
Rhode Island C
Southeastern Massachusetts U
U.S. Merchant Marine Academy, N.Y.
University of Guam
Westfield State College, Mass.
Worcester State College, Mass.

Two-Year Institutions

C C of Allegheny Cnty, Pa.
C C of Baltimore, Md.
C C of Philadelphia, Pa.
Bristol C C, Mass.
Bucks Cnty C C, Pa.
Chicago City Colleges, Ill. (7)
Columbia-Greene C C, N.Y.
Dutchess C C, N.Y. (with NEA)
Eau Claire Tech Inst, Wis.
Fashion Inst of Tech, N.Y.
Henry Ford C C, Mich.
Highland C C, Ill.
Highland Park C, Mich.
Illinois Valley C C
Joliet J C, Ill.
Lincoln Land C C, Ill.
Lake Michigan C, Mich.
Madison Area Tech C, Wis.
Milwaukee Area Tech C, Wis.
Middlesex Cnty C, N.J.
Montclair St C, N.J.
Moraine Valley C C, Ill.
Morton C, Ill.
Nassau C C, N.Y.
Northeast Wisconsin Tech Inst, Wis.
Olympia Vocational Tech Inst, Wash.
Onondaga C C, N.Y.
Prairie St C, Ill.
Rockland C C, N.Y.
Seattle C C, Wash.
Tacoma C C, Wash.
Thornton C C, Ill.
Waubonsee C C, Ill.
Wayne Cnty C C, Mich.
Westchester C C, N.Y.
Washington Tech Inst, D.C.

AMERICAN ASSOCIATION OF UNIVERSITY PROFESSORS

Four-Year Institutions

Ashland College, Ohio
Bard C, N.Y.
Dowling C, N.Y.
New York Inst of Tech
Oakland U, Mich.
Polytech Inst of Brooklyn, N.Y.
U of Rhode Island
Rutgers U, N.J.
St. John's U, N.Y.

Two-Year Institutions

Belleville Area C, Ill.

INDEPENDENT AGENTS

Four-Year Institutions

Fordham U Law School, N.Y.
U of Scranton, Pa.
U of Wisconsin-Madison (teach. assts.)

Two-Year Institutions

Bay De Noc C C, Mich.
Grand Rapids J C, Mich.
Kirtland C C, Mich.
Macomb Cnty C C, Mich.
Niagara Cnty C C, N.Y.
Western Wisconsin Tech Inst
West Shore C C, Mich.

SOURCES: NEA, AFT, AAUP

DISCUSSION ITEM
PART A 1

Not for Publication or Quotation

D R A F T

4-25-72 Proposed by
LCME Task Force on Accreditation Policy
for transmittal to LCME

PROGRAMS IN THE BASIC MEDICAL SCIENCES

I. Introduction

This is a statement of the Liaison Committee on Medical Education representing the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association*. The principal policy statement of the Liaison Committee, setting forth the general criteria for the medical school accreditation process, is "Functions and Structure of a Medical School." This document is intended as a supplement to that statement; its purpose is to enunciate the Liaison Committee's policy with respect to those programs in the medical education continuum preparatory to but not culminating in the award of the M.D. degree.

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

II. Scope and Setting

The education of the physician should cover his entire life span. This continuum of learning consists of a series of sequential educational experiences available to the student of medicine at the same or different institutions. The sequence includes the phases as depicted in the following table:

Program Phase	Curriculum	Institutional Responsibility
Premedical (BS, AB)	Undergraduate - Baccalaureate	At College or University
Undergraduate Medical (M.D.)	Basic Medical Science and Clinical Science	Medical School
Graduate Medical	Internship and Residency	Medical School, Teaching Hospital
Continuing Education	Varied available experiences in advanced clinical and scientific education	Professional Associations, Medical Schools, Teaching Hospitals

While in the past the different program phases were (and are) offered as independent curricular elements, efforts are being made presently to achieve a greater degree of programmatic integration despite the possible geographic and institutional separation of the individual educational components.

The Liaison Committee on Medical Education, as the recognized accrediting agency for medical schools, has jurisdiction over those programs operating in the interval between premedical and graduate medical education,

i.e., programs leading to the M.D. degree. In implementing its responsibilities, the Liaison Committee henceforth anticipates that the medical school or schools awarding the M.D. degree will serve as principal coordinator of the appropriate resources necessary for the educational process leading to the M.D. degree. This is the case whether these resources are concentrated in a geographically discrete academic center or available as component parts of a regional network or system. Education of a physician requires careful overall planning with a high degree of continuity in purpose and objectives. Assurance of quality in the instructional process at all levels is essential. The program in the basic medical sciences should be coordinated with the student's previous academic experience in the premedical curriculum, with the total content of the M.D. degree program and with graduate medical education.

The Liaison Committee has categorized the types of basic medical science programs that it will consider for accreditation as follows:

(1) Existing two-year programs accredited or provisionally accredited,

(2) New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium, and

(3) New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case the program will be accredited as a component of the M.D. degree-granting institution, or institutions.

III. Definition and Mission

Some of the more general elements considered essential for a program in the basic medical sciences are outlined below. More specific items are discussed later in this document under the headings of Educational Program, Administration and Governance, Faculty, etc.

(1) The program must be an integral part of an accredited* academic institution which will assume responsibility for the quality of the program. The institution must demonstrate cognizance of the special nature of the program and make administrative arrangements conducive to its implementation and operation. Depending on local circumstances and particular need, this may include flexibility relative to organizational customs in terms of program development, faculty salaries, student selection, etc.

(2) The program in the basic medical sciences should have a clear definition of its goals and objectives. When the objectives are clearly defined, they should be made familiar to faculty, students and candidates for admission so that efforts of all will be directed toward their achievement. This requires evaluation of the progress toward the attainment of these goals and objectives.

(3) A faculty of competent medical educators must be responsible for the program and should offer graduate programs of high quality in the relevant disciplines.

(4) Administrative responsibility for the program must rest with a dean or director who has adequate authority with respect to the necessary resources such as faculty, budget, space, library, learning resources, research facilities, etc.

(5) The program must exist in an environment that provides for

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* Accreditation by regional accrediting agency.

the student a firm identification with human medicine. This usually requires that there be a program of graduate clinical medical education at an affiliated hospital where faculty and house-staff can serve as role models for the student.

(6) There must be a well defined mechanism for student selection and formal acceptance into the program, evaluation of student performance, and determination of qualification for transfer into a clinical program offering the M.D. degree. At a specific point in the program the student must be identified and formally registered as a medical student.

(7) There must be documentation of the formal relationship with the institution which will grant the M.D. degree, including a description of its participation in admissions, curriculum planning, student advancement, student transfer, and appointment of faculty for the medical education program.

IV. Educational Program

The educational program in the basic medical sciences assumes that the students will have completed the premedical program. It offers them an education which will prepare them adequately for entrance into the clinical program of a medical school. Each student should acquire a foundation of knowledge in the basic sciences that will permit the pursuit of any of the several careers that medicine offers. Instruction in subject matter of the sciences basic to clinical medicine includes gross and microscopic anatomy, biochemistry, physiology, neurosciences, behavioral sciences, genetics, microbiology, pharmacology, pathology, and introduction to clinical medicine. However, the scope and depth of experience offered in any of these disciplines should be coordinated with past experience of the student in the premedical education and with the anticipated performance requirements in the clinical program. In some institutions the basic sciences have become an integral part of the premedical education contributing credit toward a bachelor's or even a master's degree.

It is of utmost importance that instruction not be conducted exclusively in the primary basic sciences without any experience in clinical medicine. The purpose of exposure to clinical medicine in the basic medical sciences education is to facilitate the correlation of the scientific and clinical aspects of medical knowledge as well as to reinforce the students' motivation for medicine and provide them with necessary attitudes, skills and techniques. The experience requires careful planning with the participation by qualified teachers of clinical medicine who are competent in and familiar with both the basic and the clinical sciences.

It is desirable for the faculty to include individuals skilled in educational technology to assist in introducing new educational methods

in the preparation of self-study materials and in developing a system of student evaluation. Of particular significance is the need to determine the level of student competence and readiness for transfer into an affiliated clinical program.

V. Administration and Governance

Programs in the basic medical sciences must be part of an accredited college or university. Officers and faculty for the program should be appointed by, or in the authority of, the board of trustees of the institution. The chief official of the program, who may be a dean or director, must have ready access to appropriate university officials. He should also have authority over (or guaranteed access to) the necessary resources such as faculty, budget, space, library, learning resources, research facilities, etc.

The program should be organized to accomplish its objective. Whether the program does or does not constitute a separate college or school, this is best accomplished through a recognizable organization of faculty including a committee structure which encompasses the admission, promotions, curriculum, library, animal care functions, and others necessary to fulfill its mission. Consideration should be given to student representation on committees.

The governance of the program in basic medical sciences should include substantive representation from the affiliated medical school in order to assure coordination of the program with the objectives of that institution, particularly in the area of curriculum, student evaluation, and promotion, and faculty appointments.

The manner in which the institution is organized, including the responsibilities and privileges of administrative officers, faculty and students should be clearly described and published.

VI. Faculty

The faculty must consist of a sufficient number of skilled teachers and investigators from the biological, behavioral, and clinical sciences to achieve the objectives of the program. The specific fields to be represented will be determined in part by the prerequisites set by the affiliated clinical program and do not have to be structured in any set pattern of departmental or divisional organization. A significant portion of faculty effort should be devoted to the facilitation of learning by those who enroll as students. In addition to the education efforts of the faculty, scholarly productivity should be encouraged. Depending on the discipline involved, the basic science faculty in the program will find it important to retain strong ties with their counterparts in the arts and sciences programs. Thus, the program in the basic medical sciences will draw academic sustenance from the more basic as well as the more applied portions of their disciplines. It will depend on the skills of the academic and administrative leaders of the program to provide conditions which permit this integration.

Physicians practicing in the community may contribute significantly to the educational program, but do not obviate the need for full time physician-teachers on the faculty.

The dean or director should establish mechanisms to facilitate full faculty participation in medical program affairs. The faculty should meet often enough to provide an opportunity for all to discuss, establish, or otherwise become acquainted with policies and practices. Usually a small committee of the faculty works closely with the dean or program director in developing policy and programs.

Nominations for faculty appointment should involve participation of faculty, the dean or director, and the M.D. degree-granting institution, the role of each customarily

varying somewhat with the rank of the appointee and the degree to which administrative responsibilities may be involved. Reasonable security and possibility for advancement in salary and rank should be provided.

VII. Students

The faculty of the program or the institution has the responsibility to determine the number of students that can be supported by the program and to define the qualifications students should have to study basic medical sciences and medicine. Decisions regarding admission to medical school should be based not only on satisfactory prior scholastic accomplishments, but also on such factors as personal and emotional characteristics, motivation, industry, character, resourcefulness, integrity and health. Information about these factors can be developed from college records of academic and nonacademic activities, letters of recommendation, admission tests, and personal interviews. There should be no discrimination on the basis of sex, creed, race or national origin. In selecting students attention should be given to the potential as physicians as well as to the anticipated performance in the basic science program. Consideration should be given to obtaining the advice and participation of practicing physicians in the admissions process.

Ordinarily, at least three years of undergraduate education are required for entrance into medical school, although a number of medical schools have developed programs in which the time spent in college prior to entering medical school has been reduced even further. The medical school should restrict its specified premedical course requirements to courses that are considered essential to enable the student to cope with the medical school curriculum. A student preparing for the study of medicine should have the opportunity to acquire either a broad liberal education or, if he chooses, to study a specific field in depth according to his personal interest and ability. Advanced standing may be granted for work done prior to admission. If needed, supplementation of the student's program may be required by the accepting school.

There should be a system for keeping student records that summarize admissions, credentials, grades and other records of performance in medical school and, where possible, information regarding the performance of the student during the clinical training. These records should reflect accurately each student's achievement and ability, including a written evaluation of each student by his instructors.

It is important that there be available an adequate system of counseling suitable to the needs of the professional student. Such counseling is especially critical for those students who may require remedial work. Academic programs allowing students to progress at their own pace are acceptable, however. Such programs necessitate provisions for sound academic advising.

There should be a program for student health care that provides adequate clinical care for the students.

VIII. Finances

Sound and adequate financial support should be available to the institution to conduct the medical programs in a satisfactory manner. Budgeting should reflect as accurately as possible the educational, research and service components of the program. There should be diverse operating support including long-term committed resources. The program cannot depend primarily on the income derived from student fees. Operating support in the form of volunteer teaching should be shown in the budgetary planning of the program. Failure to include these costs creates an unrealistic picture of the genuine expenditures necessary to conduct a program and may lead to serious misunderstandings if voluntary teaching commitments change.

Special attention must be paid to providing financial aid for students, since it is desirable that economic hardship not hinder the acquisition of an education in medicine.

IX. Facilities

The medical program must have the assured use of buildings and equipment that are quantitatively and qualitatively adequate to provide an environment conducive to maximum productivity of faculty and students in fulfilling the objectives of the school. Geographic proximity between the preclinical and clinical facilities is desirable. The facilities should include faculty offices and research laboratories, student classrooms and laboratories, access to ambulatory care facilities and a hospital of sufficient capacity for the educational programs, and a library.

Access to a well-maintained and catalogued library, sufficient in size and scope to support the educational programs that are operated by the institution, is essential to a program in the basic medical sciences. The library should receive the leading medical periodicals, the current numbers of which should be readily accessible. The library and other learning resources also should be equipped to allow students to gain experience with newer methods of receiving information as well as with self-instructional devices. A professional library staff should supervise the development and operation of the library. Library policies should be responsive to the needs of the program of medical education as articulated by the medical faculty.

X. Accreditation

The American Medical Association, through its Council on Medical Education, and the Association of American Medical Colleges serve as the recognized accrediting agencies for medical schools and for programs in the basic medical sciences. Though retaining their individual identities, both groups work very closely in this activity through the Liaison Committee on Medical Education. To be accredited, a medical school must be approved by the Liaison Committee on Medical Education, by the Council on Medical Education and be offered membership in the Association of American Medical Colleges. This is granted when it has been established by means of a survey conducted by the Liaison Committee on Medical Education that the institution is conducting a sound educational program. The Liaison Committee representing the voluntary professional sector includes a representative from the government and the public, and is recognized by the National Commission on Accrediting, the United States Commissioner of Education, the Secretary of Health, Education and Welfare, and various state licensure boards as providing the official accreditation for medical education.

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

An institution for higher education must be fully aware of the total responsibilities attendant with the initiation of a program in the basic

medical sciences. For some institutions it would be unrealistic to consider operating a program in the basic medical sciences because of the sophisticated research, teaching and service programs invclved. The quest for prestige should not be a predominant factor in the initiation of such programs. Any institution planning a program in the basic medical sciences must examine objectively and realistically its qualifications to offer the program and should seek detailed information early in the planning process. Strength in the basic biomedical and social sciences and other resources are assets.

It is the intent that newly developing programs in the basic medical sciences should be surveyed several times during the initial years of active existence. Provisional approval is granted initially and definitive action is considered during the final year of instruction afforded the first class of students.

Existing programs are surveyed at regular intervals as part of the survey of the affiliated medical school. Every attempt is made to fulfill requests for interim surveys as a consultant service to the medical schools.

Further information about accreditation can be obtained from the Secretary, Council on Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, or from the Director, Department of Institutional Development, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036.

ACTION: The Executive Council approved the LCME's April 26, 1972 version of the "Functions and Structure of a Medical School" and recommended it to the Assembly for approval.

FUNCTIONS AND STRUCTURE OF A SCHOOL OF THE BASIC MEDICAL SCIENCES

ACTION: The Executive Council approved in principle ~~two~~ policy statements (listed below) of the LCME to assist in developing the final version of the "Functions and Structure of a School of the Basic Medical Sciences." It was agreed that the previously considered "Resolution on the Interaction of Basic and Clinical Sciences" would be transmitted to the LCME along with these statements.

I. The Liaison Committee has categorized the types of basic medical science programs that it will consider for accreditation as follows:

(1) Existing two-year programs accredited or provisionally accredited

(2) New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium,

and

(3) New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case the program will be accredited as a component of the M.D. degree-granting institution or institutions.

NOT FOR PUBLICATION OR QUOTATION

THE AMA COUNCIL ON MEDICAL EDUCATION HAS TAKEN SIMILAR ACTION.

DISCUSSION ITEM
PART A 2

ESSENTIALS FOR EDUCATION OF THE PHYSICIAN'S ASSISTANT

I. Introduction

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

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

II. Sponsorship

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

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

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

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

III. Educational Goals

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

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

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

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

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

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

IV. Administration

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

V. Faculty

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

VI. Facilities

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

VII. Finances

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

VIII. Educational Program

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

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

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

(a) recording of the patient's chief complaint

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

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

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

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

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

and

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

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

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

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

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

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

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

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

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

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

IX. Selection of Students

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

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

X. Accreditation

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

Procedures:

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

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

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

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

DISCUSSION ITEM D

POLICY STATEMENT OF THE AAMC ON THE PROTECTION OF HUMAN SUBJECTS

There have been a number of widely publicized incidents recently concerning major health research projects (the Tuskegee Syphilis Experiment, for example) which have raised serious questions about the ethics of certain kinds of research and the adequacy of government supervision of Federally-supported research. This is not a new issue but recent newspaper articles have created new interest in it. This interest is being reflected in an increasing number of Congressional proposals to study the ethics of biomedical research and to extend tighter Federal control over the kinds of research receiving Federal support. Bills have been introduced to establish study commissions on the ethics of research, to ear-mark a percentage of Federal research funds to the study of the implications of the research, to prohibit Federal research support unless the human subjects of the research are fully informed of the implications and dangers of the project, and most recently Mr. Javits has introduced a bill to amend the Public Health Service Act by inserting a new section concerned with the protection of human subjects.

RECOMMENDATION

It is recommended that the Executive Council review and approve the policy statement listed below:

> For moral, ethical, and legal reasons, it is essential to protect the rights and welfare of human subjects involved in biomedical research. The Association of American Medical Colleges believes that the primary responsibility for safeguarding the rights and welfare of human subjects properly lies with the individuals and institutions conducting the research.
>
> Accordingly, the AAMC supports the view that a review procedure designed to carefully monitor the moral, ethical, and legal aspects of human experimentation is an integral part of all biomedical research, both Federally and non-Federally funded. This review should apply as a minimum standard the NIH Guidelines for the Protection of Human Subjects and would best be accomplished by a diversified group representing basic science and clinical faculty, students, and appropriate members of the community (including ministers and lawyers).

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

SEP 12 1972

SEP 11 1972

Marjorie P. Wilson, M. D.
Secretary, Liaison Committee
on Medical Education
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Dr. Wilson:

Please accept my apology for the delay in responding to your letter of August 3 concerning my action on the request of the LSU School of Medicine at New Orleans for a waiver of the mandated requirements of the Comprehensive Health Manpower Training Act of 1971. Enclosed is a copy of my letter to Dr. William H. Stewart which explains the basis for my decision and, I believe, covers the points raised in your letter.

With best regards,

Sincerely,

Elliot L. Richardson

Secretary

Enclosure

SEP 12 1972

WASHINGTON, D.C. 20201

AUG 24 1972

William H. Stewart, M.D.
Chancellor
Louisiana State University
Medical Center
1542 Tulane Avenue
New Orleans, Louisiana 70112

Dear Dr. Stewart:

Thank you for the views you and Dr. Nelson expressed in your letter of July 6 opposing my decision to approve the recommendation of the National Advisory Council on Health Professions Education. I regret the delay in replying. Since you have been advised of the reasons for the Council recommendation, I shall not repeat them here. In addition to the Council's position, I was fully informed on the basis for your appeal prior to making my decision.

The legislative history of the Comprehensive Health Manpower Training Act of 1971 clearly indicates the strong intent of Congress that every effort be made to meet the mandated requirements of the Act wherever possible and that any waiver be granted only in exceptional circumstances. As you know, my decision must include consultation with the Council.

While I thought that good points were made on both sides of the issue in the case of the LSU School of Medicine at New Orleans, it seemed to me that, on balance, the arguments supported the recommendation of the Council, particularly after it had, at our request, reviewed the matter a second time and confirmed its initial position. You are, of course, aware that a number of other schools had requested waivers and all but a few had been recommended for disapproval by the Council. In all cases to date, the Council's recommendations have been approved. I have relied heavily on the Council's advice.

The Council considered the findings of the Liaison Committee on Medical Education but concluded that they did not establish the fact that the quality of education would be reduced. This judgment was rendered as part of the Federal Government's responsibility for meeting the requirements of Law, regulations and public policy in making a final decision on awarding a grant. It in no way suggests any intent on the part of the Federal Government to interfere with the process of accrediting a medical school or to set standards for medical education.

Your concern about the possible loss of accreditation next year is understandable. Waiver requests are reviewed annually and I assure you that, if you submit such a request, it will be reviewed without prejudice.

With best regards,

Sincerely,

Secretary

cc: Norman C. Nelson, M. D.

9/13/72

D R A F T

Resolution on the Ethical, Moral and Legal Aspects of Research Involving Human Beings

The body of knowledge and technology that underlies the practice of medicine and the health professions remains critically limited and highly empirical in nature. There has not yet evolved a general and unified body of law and theory encompassing the phenomena of life and the nature of disease and health, such as exists in the physical sciences. The practice of medicine therefore involves varying degrees of unpredictability, hazard and risk which must be carefully assessed against the possible benefits to be achieved. The making of such judgments in the interest of the patient being treated is the essence of the ~~legal~~ clinical acts of the physician. His entire professional education is aimed at providing the soundest basis of knowledge and skill for the making of such judgments with full understanding of the ethical, moral and legal obligations involved.

In like manner, the further advance of medical knowledge involves the penetration of the unknown with an even greater degree of hazard and risk. The latter stages of this scientific process inescapably require observation involving the human being. Without this final process of controlled clinical investigation, there can be no progress in medicine, and mankind must be condemned to bear the immeasurable hazards ~~for~~ of continued ignorance.

Because both the welfare of the human beings involved and the advancement of knowledge are being sought, the assessment of the ethical, moral and legal aspects of research activity involving the human being requires judgments beyond those that can be brought by the investigative team involved.

Therefore, be it resolved that the Executive Council of the Association of American Medical Colleges supports and endorses the view that ~~this~~ the submission of proposed investigative activity involving the observation of human beings to review by disinterested scientific, professional and lay judgment to assess the ethical, moral and legal aspects of such ~~xxxxxxxxxx~~ research and to assure safegarding the welfare of the individuals involved, is an integral and essential instrument of the process of biomedical research. It is the responsibility of all institutions whose programs include investigative activity utilizing the human being to establish and assure the ~~effective~~ effective functioning of a framework for institutional review of such research. All ~~of which~~ investigative activity, regardless of source of support, must be reviewed within such a framework as a part of the normal working of a good scientific establishment. ~~and~~ The inculcation of these attitudes, and ~~and~~ experience with the procedures involved is an essential ingredient of a sound medical education program. The review procedures of such groups should apply, as a minimum standard, the NIH guidelines for the protection of human subjects.

A REQUEST FOR REACTION TO THE COD MEETING IN PHOENIX

This meeting was planned by the Administrative Board and the Program Steering Committee in response to signals which came in various ways from the COD membership. Your comments will be of great assistance in improving our efforts in the future. You need not sign the form unless you wish to.

LOGISTICS

Length of the meeting and timing:

About right 52
Too long 16
Too short
Should not be during the weekend 18
Should be on weekend 24
Sat. OK 3
No Sun. 1

Comments:
1/2 day too long

Location:

Would like to return to Phoenix area next year 20
Would like to return to Arizona Biltmore 20
Would prefer another location in the same area 9
Would prefer another geographic area next year 23
(please say where)
Comments and suggested cities and hotels:
(See attached for list).

Accommodations:

Fine 48
Accep-ible 2
Too expensive 39
Prefer different atmosphere-please specify

Comments:
Option-Amer. or Eur. Plan 2
Too plush 5
not a resort 1
Univ. will not pay level 3

AAMC Staff Support:

Could be improved by--

Meeting Rooms:

Could be improved by--
Better audio 7
Better visual 3

PROGRAM

Did the meeting meet your expectations? How so? How not?

Yes 47
No 10 almost 4

Was the meeting useful? In what way?

What was your reaction to the treatment of the subject of the meeting?

What was the best part of the meeting?
(See attached sheet)

What subjects would you like to see dealt with at future COD meetings?

Suggested theme for 1973 spring meeting?
(See attached sheet)

Should the Administrative Board develop the theme for the year or for several years and plan the agendae of several COD meetings to address a related group of topics in depth?

Other Comments:

PRESENTATION METHODS

Scheduling

Liked the free time in the afternoon 52
Prefer to have evenings free 8

Other comments:

Too much free time 2
Shorter Sessions 1
Evening Sessions a waste 1
Shorter evening Sessions 1

If resort free afternoon and if city free evening 2
Free time at end 1

PARTICIPATION AND FORMAT

The Program Steering Committee considered various arrangements and decided against breaking into small groups for discussion of issues, believing the participants would prefer to reamin together for the formal discussions of papers. We would appreciate your general views.

The group was too large for adequate interchange	25
Would prefer an opportunity for smaller group discussion next time	26
The format used provided for adequate interchange and discussion	32

Suggestions re format:

Semi-circular	1
Lecture Hall	1
No small groups	2

SPEAKERS

Would like to have more speakers who are not deans	28
Who are outside the medical community	19
Who are expert in (See attached sheet)	

RESULTS (PUBLICATIONS)

Believe the spring COD meeting should result in a "proceedings"	11
Believe this meeting should be completely off the record	38

GENERAL EVALUATION

The meeting was a success	40
It was a dud, no repeats please	
Should become an annual event for COD	45
OK for first try, but needs fixing as follows:	

FUTURE DATES

In 1973 I would prefer April 5,6 and 7 25
April 12, 13 and 14 12

or

Either 15 Neither 1 Too early to say 3

Instead of meeting Thursday through Saturday,
I prefer No Wed. Night 1 Fri, Sat., Sun. 9 Fri. - Sat. 1

Tues. - Fri. 1 Wed. - Fri. 2 Thurs. - Fri. 2

In 1973 FASEB meets April 15 - 20
Atlantic City meetings April 28 - May 2
Easter is April 22

We anticipate that AAMC as a whole will meet only once in 1973 at the Annual Meeting in the fall; at its next meeting the Executive Council will consider a proposal to eliminate the February meeting in Chicage.

Comments re dates:
March - 1
Prefer only two days - 1

OTHER COMMENTS: Please feel free to make comment on any aspect of the meeting.

Obviously, we are not expecting to make any statistical analysis of the responses. We are looking for reactions and ideas. Your thought and time in completing the questionnaire is much appreciated.

Please return to:
Marjorie P. Wilson, M.D.
Suite 200, One Dupont Circle
Washington, D.C. 20036

LOCATIONS SUGGESTED FOR NEXT MEETING:

Central	5		
East	1		
Mid-West	4		
West	3		
Albuquerque	1	(New Mexico 2)	
Atlanta	3	(Regency Hyatt House 1)	
Atlantic City	1		
Biloxi, Miss.	1		
Camelback	1		
Colorado Springs	5		
El Dorado	1		
Florida	3	(Fort Lauderdale 1)	
Greenbrier, W. Va.	3		
Homestead, W. Va.	3		
New Orleans	5	(Royal Orleans Hotel 1)	
Pinehurst, N. Car.	1		
Hilton Head, So. Car.	1		
San Antonio	1	(Texas 2)	
Washington, D.C.	2		
Williamsburg, Va.	4		
Airlie House, Va.	1		
Indiana	1		
Boston	1		
Hawaii	1		
La Jolla	1		
Caribbean	1		

BEST PART OF THE MEETING

Brown, Ray	3	Discussions	8
Byrom, F.	6	Non M.D. type speakers	1
Cooper, J.	8	Thrusday	1
DuVal, M.	20	Fri. P.M. & Sat, A.M.	10
Evans, J.	1	Fri. AM	2
Lewis, I.	4	Morning Sessions and Free Afternoons	1
Rosenblith	4		

SUGGESTED THEMES FOR 1973 SPRING MEETING

1. The Health Care "Team"--Where are the Educational Models?

2. Responsibility of the Medical Schools in contributing to the Restructuring of the Health Care Delivery System.

3. Organizational Models

4. Health Care Delivery--Education for--team approach / systems approach

5. Impact of HR 1, HR 1, HMO, and national health insurance programs on medical schools.

6. COD Leadership in National Health Policy -- Should we Act in Concert?

7. Public and Political Expectation of the Medical Schools -- re: Fact or Fiction of it.

8. The Responsibility of medical Education for the Distribution of Graduates within Medical Specialties and Geographically.

9. Decline of the Quality of Medical Education.

10. 1. Curriculum as It is actually working; strengths, weaknesses, and problems.
    2. Admissions as it is actually working; strengths, weaknesses, and problems.
    3. Class size and quality as it is actually working; strengths, weaknesses, and problems.

11. Evaluation

12. Is there a conflict between new styles in medical education and quality?

13. How much of the research dollar is necessary for education?

14. The examinations system in American medical education --both pre and post M.D.

15. Graduate education -- continuum of education. Who pays, etc.

16. Objectives and evaluation of medical education -- Objectives and evaluation of medical practice.

17. The definition of quality -- the measurement of quality for: a. the medical graduate b. the practicing physicians 5, 10, and 15 years later.

18. Debate on what curriculum should be

19. Financing of post-MD training

20. Responsibilities for post-MD education

21. Definition of quality

22. The impact of innovation in medical education -- good or bad?

23. 1. Will the resident be financed from other care and/or education sector and how does this influence medical college: care facility and management structure.
    2. Is family medicine in the community (95% of proposal activity) so mundane that no teaching is needed?

24. Toward a system of continuing, comprehensive medical education,

25. Improving medical education

26. How to develop sensible faculty projections for 1978 -- include use of community hospitals.

27. Management of the academic medical center

28. What is our corporate adversary position?

29. Long range planning

30. Definition of the M.D. -- elaboration of

31. Use of capitation funds, minority problems

32. Management and planning

33. Funding of health services, education and research

34. How do we deal with decentralization of organization for specific goals in vertical structure?

Tabulated

20 received

AAMC EXECUTIVE DEVELOPMENT SEMINAR

Endicott House
Dedham, Massachusetts

September 2-8, 1972

In order to help the Steering Committee in planning additional Phase I activities, we would appreciate your responses to the following questions.

A. General Reactions to the Program

1. Pace of presentations

a) Generally too fast — 1
b) Just the right pace — 14
c) Generally too slow — 4

2. Use of concrete examples (cases, illustrations)

a) Too few examples discussed — 3
b) Adequate use of examples — 14
c) Too much time spent on examples — 3

3. Use of readings during total group lectures and discussions

a) Too little use made of readings — 2
b) Adequate use made of readings — 18
c) Too much time spent on readings —

4. Daily work load -- structured class activities

a) Too light - should have done more —
b) Adequate work load — 15
c) Too heavy - should have done less — 5

B. Detailed Session Evaluations

Session	Conceptual Framework for looking at problems Poor 1 2 3 4 5 Excellent Circle		Application Possibilitie Poor 1 2 3 4 5 Excellent Circle
Effective Organization - Managerial Strategies and Styles	1 2 3 4 (6) 5 (12)	4.7	1 2 3 (2) 4 (5) 5 (10)
Open Systems Planning	1 2 3 (4) 4 (5) 5 (7)	4.3	1 2 (1) 3 (4) 4 (4) 5 (6)
Planning for Change - Mid-State University Case	1 (1) 2 (3) 3 (6) 4 (7) 5 (2)	3.2	1 (1) 2 (3) 3 (7) 4 (3) 5 (3)
Function of Power in Organizations	1 (1) 2 (4) 3 (4) 4 (2) 5 (9)	3.5	1 2 (3) 3 (3) 4 (3) 5 (9)
Planning and Control Concepts	1 2 (1) 3 (1) 4 (12) 5 (6)	4.3	1 2 (1) 3 (1) 4 (7) 5 (10)
Program Planning and Budgeting System (PPBS)	1 2 (2) 3 (6) 4 (10) 5 (2)	3.7	1 2 (2) 3 (5) 4 (7) 5 (5)
Department of Interior Case	1 2 (4) 3 (10) 4 (5) 5 (1)	3.2	1 2 (6) 3 (7) 4 (4) 5 (1)
Developing Health Center's Planning and Control System Exercise	1 (1) 2 (0) 3 (11) 4 (4) 5 (2)	3.1	1 (1) 2 3 (5) 4 (4) 5 (9)
Management Information Systems	1 2 (2) 3 (7) 4 (9) 5 (2)	3.6	1 2 (3) 3 (2) 4 (6) 5 (7)
Managing Professionals	1 (4) 2 (6) 3 (2) 4 (5) 5 (2)	2.6	1 (2) 2 (3) 3 (3) 4 (4) 5 (5)
Organization Designs	1 2 3 (3) 4 (3) 5 (13)	4.5	1 2 3 (1) 4 (4) 5 (13)
Decision Making - Search, Design, Problem Finding	1 2 3 (7) 4 (3) 5 (6) (4)	3.5	1 2 3 (3) 4 (4) 5 (6) (6)
Decision Making Systems Analysis - Role of Models	1 (3) 2 (5) 3 (5) 4 (4) 5 (3)	2.9	1 2 (6) 3 (6) 4 (4) 5 (3)
Decision Making - Development of Simulation Model	1 2 3 (2) 4 (7) 5 (11)	4.5	1 2 (1) 3 (05) 4 (5) 5 (9)
Intergroup Relationships - Conflict Management	1 (1) 2 (1) 3 4 (7) 5 (9)	4.4	1 2 3 (1) 4 (1) 5 (4) (12)
"Unfinished Business" - Discussion	1 2 3 4 5		1 2 3 4 5

C. On the basis of your experience this week, would you recommend that other deans attend a similar program?

1. I would urge them to attend. It has very high relevance to deans. 18

2. I would say that they would probably find it useful. 2

3. I would say that for general managerial development this is a good program. _____

4. I would not take any strong position. _____

5. I would suggest they not attend. _____

D. General Suggestions for Improving the Course.

Please list additions or deletions of program elements and content. Any suggestions for changes in presentation, faculty, scheduling, group size, etc., etc.

1. The Council of Deans recommends that the AAMC undertake a major study of undergraduate and graduate medical education programs, a study which has at its focus the definition of the quality of their product in quantifiable terms. This should include: (A) The development of standards and priorities by which the quality of educational programs may be assessed; and (B) The identification of the relationship between the performance of the physician and his educational experience.

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

The Administrative Board of the COD approved the Guidelines for Sub-Council Organizations as modified by the following amendments:

B. GROUPS

2. All Group activities shall be under the general direction of the AAMC President or his designee from the Association staff *and shall relate to the appropriate Council(s) as determined by the Executive Council.*

3. Groups may develop rules and regulations subject to the approval of the AAMC President *and the Executive Council.*

5. The activities shall be reported periodically to the (*delete Executive*) Council*(s) designated under B 2 above.*