AGENDA

Council of Deans
Administrative Board

November 3, 1972
Champagne Room, Hotel Fontainebleau
Miami, Florida
12:00 noon - 1:30 pm
(Luncheon)

I. Minutes of Previous Meeting

II. Future Meetings of the Administrative Board

III. Review of the Council of Deans Meeting Agenda

IV. Discussion of the Spring 1973 Spring COD Meeting

V. New Business

A. Suggestion of Deans of the Northeast Region that the Business Officers Section (or its successor "group") be requested to study the magnitude and impact of the unreimbursed indirect costs associated with grant supported activities.

B. Other Business

INFORMATION ITEMS

1. Minutes of the Health Services Advisory Committee, Subcommittee on the Quality of Care

   -Comments of Dr. Davis Kessner, National Academy of Sciences, Institute of Medicine, Health Services Research Study
   -Commission on Quality Health Care Assurance (Senate Committee Report Excerpt)

2. "Profiles of U.S. Medical School Faculty, FY 1971"

3. Minutes of the September 19, 1972 Meeting Task Force on Cost of Graduate Medical Education and Faculty Practice Plans

4. Minutes of the RMP-CHP Committee

5. Minutes of the COTH Administrative Board Meeting

6. Minutes of the CAS Administrative Board Meeting (without Attachments)

Association of American Medical Colleges

MINUTES

Administrative Board
of the
Council of Deans

September 14, 1972
9:00 a.m. - 4:00 p.m.
AAMC Headquarters
Washington, D.C.

PRESENT:

(Board Members)

Carleton B. Chapman, M.D.
J. Robert Buchanan, M.D.
Ralph J. Cazort, M.D.
Clifford G. Grulee, M.D.
William F. Maloney, M.D.
William Mayer, M.D.
Sherman Mellinkoff, M.D.

(Staff)

John A. D. Cooper, M.D.
Amber Jones
Robert Kalinowski, M.D.
Joseph Keyes
Joseph Murtaugh
J. R. Schofield, M.D.
Marjorie P. Wilson, M.D.

ABSENT:

Emanuel Papper, M.D.
Harold C. Wiggers, Ph.D.

I. CALL TO ORDER

Dr. Carleton Chapman called the meeting to order shortly after 9:00 am.

II. MINUTES OF THE PREVIOUS MEETING

The Minutes of the July 12, 1972 COD Administrative Board were approved as circulated in the Agenda Book.

III. ORGANIZATION OF FACULTY REPRESENTATIVES

The Board reviewed the responses to the Chairman's letter requesting an assessment of the proposal to establish an Organization of Faculty Representatives from each dean, the executive faculty and the general faculty of each institution. 52 schools responded; a plurality of the deans and the executive faculties opposed the proposal, a plurality of the general faculties favored it. 13 schools indicated that an independent Council of Faculties would be a preferable organizational structure. The Board judged that this represented no clear mandate to establish an OFR and by straw vote found only one Board member favoring either an OFR or a COF. Considering itself bound by the February COD resolution deferring Council action until such time as all regions have had an opportunity

for full discussion of the specific proposal," the Board referred the matter to the regions for further discussion with the admonition that the broad issue of faculty participation in the governance of the AAMC on an institutional basis be addressed as well as the proposed organizational structure for such participation. Any region favoring additional faculty representation on an institutional basis should give careful attention to devising an organizational structure that would be broadly acceptable. The regional discussions will be considered at the November 4 COD Business Meeting, at which time it is hoped that a COD position on the entire issue will be taken.

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

The Board received the report and commended the Committee for its work. The Board voted to forward the report to the COD for its information and endorsement with the following recommendations of the Administrative Board for specific Council action:

1. The Council of Deans recommends that the Association President and appropriate staff explore all aspects of the feasibility of a medical school admissions matching program and prepare a plan for the phased implementation of such a program for the review and approval of the COD.

2. The Council of Deans commends the efforts of the Association staff and the Group on Student Affairs in working with premedical advisors. The Council recommends that this work continue with increased emphasis on developing background information on and advising students of the range of potential careers available to those interested in working in the health field.

In addition, to these recommended action items the Administrative Board calls particular attention to the Committee's observations with respect to the American Medical College Application Service. The Board anticipates that the coming year will provide substantial evidence that the service has overcome its start-up problems and wishes to advise each nonparticipating institution to carefully evaluate this progress and to assess the potential utility of AMCAS in assisting in its own admissions process.

Finally, the Administrative Board has requested that the AAMC staff, with appropriate consultation, prepare the background material referred to in the third recommendation in the report for the review of the Board prior to general distribution.

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

The following resolution referred by the Executive Council was endorsed by the Board:

> 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.

VI. COUNCIL OF DEANS SPRING 1973 MEETING

The Board, acting as program committee for the Spring Meeting to be held in San Antonio, March 7-9, 1973, formulated as the theme of the meeting: "The Influence of Third Party Payers on Medical Education and Patient Care in the Teaching Setting." Envisioned are three sessions on this topic focusing on 1) the effect on funding, 2) the effect on faculty, and 3) the effect on the teaching program. Additional time will be set aside for a discussion with the AAMC President and for conference conclusions and actions.

A more exhaustive report of the discussion of the Spring 1973 COD Program will be drafted to appear as an attachment to these minutes.

VII. ELECTION OF INSTITUTIONAL MEMBERS

To preclude a full year delay between COD action in Institutional Membership and final election by the Assembly, the Board adopted a procedural modification in the election procedures contingent upon Executive Council and Council of Deans ratification. This action was necessitated by the fact that the Executive Council is not scheduled to meet in the interval between the COD meeting and the Assembly while the AAMC Bylaws require action in the sequence COD -- Executive Council -- Assembly. The modified sequence of actions is COD Administrative Board -- Executive Council -- Council of Deans -- Assembly.

Pursuant to this procedure the Administrative Board recommended the following actions to the Executive Council:

1. South Alabama College of Medicine to Provisional Institutional Membership.

2. University of California, Davis School of Medicine; University of California, San Diego School of Medicine; and University of Connecticut School of Medicine to Institutional Membership.

3. McMaster University Faculty of Medicine to Affiliate Institutional Membership.

Because of the Liaison Committee on Medical Education Action granting the Medical College of Ohio at Toledo only probationary accreditation, the Board judged that it would be inappropriate to elect that institution to full Institutional Membership in the AAMC at this time. Notwithstanding the fact that the traditional eligibility criteria for a change in membership status had, by a narrow interpretation, been fulfilled, i.e. the school has graduated a class of students and has been "accredited by the LCME," albeit with only probationary approval, in the Board's view, the status of Provisional Institutional Member, the current membership category of the school is the more appropriate status. The Board reasoned that, under circumstances as these, an institution which had never been awarded full approval by the LCME should not be elected to full membership in the Association. The distinction is one in name only, and changes neither the legal status of the school or its graduates, nor the school's membership privileges or responsibilities.

VIII. THE LIAISON COMMITTEE DOCUMENTS

A. Programs in the Basic Medical Sciences

The Board reviewed the current draft of the basic policy document of the LCME relating to the accreditation of undergraduate medical education programs not culminating in the M.D. degree. The Board endorsed the document "in principle" indicating its concurrance with the underlying policy enunciated: that such programs to be accredited (existing two year schools excepted under a grandfather clause) must be closely linked to an M.D. program to ensure the quality of the undertaking and the transferability of the students.

B. Essentials for the Education of the Physician's Assistant

The Board endorsed the principle enunciated in this early version of a proposed LCME document: that these is an appropriate role for the LCME in the accreditation of certain programs designed to educate physician's assistants.

IX. FOLLOW-UP OF COD "PHOENIX" RESOLUTIONS

The Board agreed that of the Association's activities, the Longitudinal Study, further refined and pursued, offered the best potential for relating the educational experience of the student to his ultimate performance in medical practice. There was additional discussion which raised the issue of the responsibility of the medical school in the maintenance of data relating to the practice of their graduates.

The Resolution relating to the assessment of the quality of medical care was referred to the AAMC Health Services Advisory Committee which in turn established a subcommittee to examine the issue in some depth. That subcommittee will meet on September 29, 1972 and prepare a report for presentation to the Council of Deans on November 3, 1972.

X. POLICY STATEMENT OF THE AAMC ON THE PROTECTION OF HUMAN SUBJECTS

The Board endorsed the following policy statement (In the third sentence the Board added the word "members" after faculty):

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

XI. RESOLUTION ON VA POLICY RELATING TO DUAL PAYMENT OF HOUSE STAFF

The Board endorsed the following resolution:

> The Executive Council of the AAMC considered Policy Circular #10-72-184 at its meeting on September 15, 1972. This policy, permitting dual payment to medical residents for performing duties normally expected of house officers, will have an impact upon institutional policies far beyond the limited interests of the affiliated VA Dean's Committee Hospitals. The Executive Council is disturbed that there was no prior consultation with the AAMC staff or the members of the VA-AAMC Liaison Committee prior to the formulation and promulgation of this policy. The Council requests that implementation be delayed until there has been an opportunity for a thorough discussion of this matter.

XII. ADJOURNMENT

The Meeting adjourned at approximately 4:00 pm.

II. FUTURE MEETINGS OF THE COD ADMINISTRATIVE BOARD

In conformance with the COD Administrative Board practice of meeting on the day prior to the AAMC Executive Council Meetings, the following schedule of Board meetings is proposed:

Adminstrative Board	Executive Council
December 14, 1972	December 15, 1972
March 15, 1973	March 16, 1973
June 21, 1973	June 22, 1973
September 13, 1973	September 14, 1973

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

MINUTES

SUBCOMMITTEE ON QUALITY OF CARE
September 28-29, 1972
Embassy Row Hotel - AAMC Conference Room
Washington, D.C.

Committee Members Present

Robert J. Weiss, M.D., Chairman
David R. Challoner, M.D.
Richard L. Meiling, M.D.
John H. Westerman

Absent

Christopher C. Fordham III, M.D.

AAMC Staff

John A. D. Cooper, M.D.
Joseph S. Murtaugh
August G. Swanson, M.D.
Marjorie Wilson, M.D.
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Stephen J. Ackerman
Lily O. Engstrom
Grace W. Beirne
Charles Fentress

Guests, September 28, 1972

Phil Caper, M.D.
Paul Ellwood, M.D.

Guests, September 29, 1972

Samuel Asper, M.D.
Robert Brook, M.D.
Robert Heyssel, M.D.
David Kessner, M.D.
William Sale
Paul Sanazaro, M.D.

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

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

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

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

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

Dr. Philip Caper, Senate Subcommittee on Health

Dr. Paul Ellwood, American Rehabilitation Foundation

Dr. David Kessner, Institute of Medicine

Dr. Paul Sanazaro and Dr. Robert Brook, DHEW

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

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

Various methodologies proposed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee discussion and recommendations

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

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

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

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

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

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

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

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

APPENDIX

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

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

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

Hawaii Medical Association EMCRO

The Hawaii EMCRO is based on the methodology developed by Dr. Beverly Payne to study the process of medical care and outcome of episodes of illness both in the hospital and in office practice. Criteria of optimal care were developed by the Hawaii Medical Association and are given weights of 0-3. The "physician performance index" (PPI) is the percentage of the weighted score performed by each physician for that illness episode.

This methodology is being implemented into on-going review through the use of local physician panels selected by the EMCRO to set "optimum care" criteria for 12 ambulatory diagnoses and 6 in-patient diagnoses. The first cycle of record abstracting began in April 1972. Both the criteria and diagnoses will be modified on the basis on feedback from each succeeding cycle. Feedback seminars with physicians have already been established, and evaluation is an on-going task.

The 12 sets of ambulatory criteria have been translated into abstract forms designed to be machine-readable in a mark-sense optical card reader, which interfaces to an inexpensive desk-top mini-computer. The abstract form constitutes one record per patient for each ambulatory illness episode, and can be processed in the system at a rate of one form per second. PAS abstract forms are still being used in the hospital setting.

Programs are presently being written to edit data and produce summary statements for EMCRO physicians to use in self-evaluation seminars or group peer review.

Methods for sampling care in both fee-for-service and prepaid settings are being devised. Care can be sampled prospectively and retrospectively under fee-for-service where claims forms are available. If all fee-for-service physicians were EMCRO members, sampling the population directly would identify those without access to care as well.

Since this project will terminate in August 1973, several avenues of self-support are being explored including expense-sharing or service fees from the participating hospitals CPHA (PAS), the Department of Social Services, and the Hawaii Medical Services Agency (HMSA - a major third party payor).

Albemarle County (Virginia) Medical Society EMCRO

The National Center for Health Services Research and Development's grant to the Albemarle County Medical Society (ACMS) establishes an Experimental Medical Care Review Organization (EMCRO) through which practicing physicians in Charlottesville and the surrounding rural areas (Albemarle, Greene, Madison, Orange, Louisa, Fluvanna, Buckingham and Nelson Counties) can evaluate the quality and efficiency of services ordered or performed by other area physicians. EMCRO employs an epidemiological approach to peer review. This broad model for assessing the quality of medical care includes not only the traditional study of hospitalization but also considers certain factors prior to admission such as primary prevention (screening), secondary prevention (case finding), and office practice, as well as those factors following discharge, including follow-up and tertiary prevention (rehabilitation).

Expert review committees develop documented criteria based on information gathered from medical literature and the survey results of local practice. The committees are composed of a combination of two to five university and town physicians. Expert committees have already established quality care criteria for the management of hypertension, gastric ulcer and hip fracture. The hypertension criteria have been approved by the General Review Committee (composed of approximately 25 Medical Society members). The criteria were submitted to the County Medical Society membership and were approved. Expert review committees recently organized to develop quality guidelines for the management of acute myocardial infarction, otitis media in children, bacterial pneumonia, urinary tract infection and appendictis. Additionally, an expert committee on office records is researching methods to improve and facilitate office record keeping. A Long Stay Committee, designed to provide effective utilization of hospitals, nursing homes, intermediate care facilities, home health services and other resources for quality care of patients at least cost, is also in operation.

EMCRO's patient care review cycle begins with the patient-physician meeting in which a diagnosis is presumably made and treatment rendered. Criteria for specific disease processes are formulated and a survey of hospital and ambulatory care in the locality is conducted. The survey results are then compared to the optimal standards of care. The computer evaluation is presented to the Medical Society membership and other doctors. The norms of care are published and lectures on specific areas are provided. Within a year the cyclic review process will recur. The actual performance of physicians again will be compared to the standards through a computer evaluation process which identifies significant gaps. These inefficiencies in patient care are relayed to the County Society which determines how significant gaps in medical practice can be closed. For those physicians who have repeatedly failed to apply any of the established guidelines, the Medical Society's EMCRO may suggest to the carriers that their claims not be honored.

The most extensive work of EMCRO is in the area of the peer review of hypertension. A preliminary study of 700 consecutive admissions in the two area hospitals has been conducted to determine the treatment of hypertensives. The hypertensive committee has also studied the yield of hypertensive intravenous pyelograms (IVP), renal arteriograms and catecholamines as diagnostic screening procedures for hypertension. Retrospective surveys of hospital and office records of patients with hypertension, hip fracture and gastric ulcer are completed and currently being analyzed.

Georgia Foundation for Medical Care EMCRO

Georgia EMCRO is a project of the Medical Association of Georgia. EMCRO develops review methods and criteria for ambulatory care, hospital, and nursing home review.

All medical care services of Medicaid recipients are reviewed by the Georgia Foundation for Medical Care under a contract with the State Health Department. EMCRO develops review methods for the Foundation, which actually performs the review. This review emphasizes cost containment within general quality assurance guidelines. Criteria of ambulatory care are being developed by specialty committees.

In conjunction with the Georgia Hospital Association, EMCRO is developing a hospital discharge abstract as a management tool for hospital administrators and as a means of strengthening hospital utilization review committees in a cooperative way. No hospital in Georgia subscribes to the Professional Activities Study (PAS) or other information service. The discharge abstract is a first step by EMCRO in quality review in hospitals.

The Georgia Nursing Home Association has requested EMCRO cooperation in designing a system of centralized utilization review for all member nursing homes. A GMCF committee is developing admission criteria along with EMCRO. An abstract is filled out on each patient admitted to a nursing home within two weeks and every six months thereafter, or more frequently if requested by EMCRO. Review includes on-site visits to nursing homes by EMCRO. On-site review can compare the data and judgements about quality gained from the abstracts with the situation observed in the nursing home.

A problem-oriented approach to review is being pursued in cooperation with J. Willis Hurst, M.D., of Emory University Medical School, where problem-oriented records are used in out-patient departments and the Department of Internal Medicine. First, a list of the most frequently encountered problems will be compiled.

Medical Care Foundation of Sacramento EMCRO

The major current thrust of the Sacramento Foundation is the development of a prepaid health plan. While this initially will cover Medi-Cal patients, the expectation is that patients under a wide variety of programs will eventually be covered. The EMCRO activity will include the development of an extensive automated data gathering and processing system. From this data, criteria of care will be developed and later used to identify exceptional practice patterns. Education programs will be aimed at the correction of these problems.

In addition to planning for the prepaid health plan, a physician and patient survey funded by the EMCRO and IEMO grants was carried out in the first year. This, in part, assessed the level of interest and potential for involvement in Foundation peer review programs.

Utah Professional Review Organization EMCRO

During the first year, the Utah EMCRO gained broad-based support for their emerging project. They initiated a pilot program of concurrent hospitalization review which has expanded under a contract with Blue Cross/Blue Shield for the Federal Employees Program. Criteria for hospital care have been developed for use in this concurrent review system.

The major thrust of the next two years will be the development and operation of an automated review program for ambulatory services under Medicaid. This will include the development of a new encounter form, ambulatory care criteria and a computer based program that will allow the identification of practice patterns differing from the criteria. An extensive data base will permit the generation of physician and patient profiles which will aid the review physician in making judgements.

In cooperation with IRMP, a continuing education program will be tailored around the educational needs identified by review.

Finally, a project for review of care in the Salt Lake City Neighborhood Health Center (an HMO) is in the planning stages. This will include the use of a control group of private practice physicians from the community.

Multnomah County (Portland, Oregon) Foundation for Medical Care EMCRO

During the first year, the Multnomah EMCRO developed criteria for ambulatory, hospital, extended, and home care. In addition, they started a pilot program of concurrent hospitalization review which is expected to expand in the near future.

During the next two years, the Multnomah EMCRO will develop and operate a program which will review the care provided to the patients of 250 volunteer physicians. This will involve the development of an encounter form to capture the needed data, and an automated system to process it. Relationships with third parties will allow the use of their data for patients who receive care from other than volunteer physicians.

Educational needs identified by EMCRO review data will be addressed in programs of continuing medical education.

Mississippi State Medical Association EMCRO

During the first year the Mississippi EMCRO developed criteria for 60 diagnoses for hospitalized patients. A sophisticated efficient system for data collection and processing has been developed. The initial comparison of care with criteria is done by computer with review of deviant cases being done by physicians using easily readible computer output forms. The data is then sent to the participating hospitals for review and action.

Initially, eight hospitals were involved in the study. In June, 1972, the criteria were sent to all hospitals in the State with an invitation to participate in the program. Indications are that a large number will take advantage of this opportunity.

Plans for the second year include consideration of the development of review of emergency room care. Enlargement of the hospital review program, planning for continuing education and the development of mechanisms for indepth analysis and evaluation of the hospital generated data.

New Mexico EMCRO

The progress of this medical care review organization has been rapid. Planning and start-up was accomplished between May and September 1971 as a result of the relationship between the State Health and Social Services Department and the New Mexico Foundation for Medical Care. Medicaid claims are processed for payment and reviewed for appropriateness of care on a Statewide basis. Criteria for care are being formulated by physician panels and will include 270 diagnoses when completed. Also to be included are admission criteria to four different levels of nursing home care as well as podiatry criteria.

The data processing aspects of the system are handled through a subcontract with the Dikewood Corporation, which owns both the hardware and software components. The annual claims processing cost by Dikewood in 1970 was about $100,000 less than that of Blue Cross. Data is entered directly by keypunching into a random access memory with no intermediate steps as in other systems. Each claim and any associated correspondence is assigned a unique number and is also microfilmed. From this data base, both patient and physician profiles can be generated over periods of up to one year. Experimentation has begun with the use of remote CRT terminals in the Foundation's regional offices. Claims will be recorded on cassettes for batch input to the central computer such that availability of computer time will not be a constraint on regionalization of review. Effort has also proceeded toward the review of problems as well as diagnoses as the Foundation moves in the direction of using problem-oriented records.

National Academy of Sciences
Institute of Medicine
Health Services Research Study

Dr. David Kessner

DRAFT: This document represents notes on which the author based his talk to AAMC's Subcommittee on Quality of Care on September 29, 1972.

QUALITY ASSESSMENT AND THE TRACER METHOD

Since medicare there has been unprecedented economic, political and consumer pressure for change in the delivery of health services. In part, this pressure has been translated into public and congressional concern for how much health services cost and the quality of the service that is purchased. The political process--which I'm sure some of you were involved in--has responded with proposals for National Health Insurance, Health Maintenance Organizations, and Peer Review Organizations--all specifying monitoring, quality assessment, quality assurance, and quality achievement.

And while it seems certain that none of these proposals will come to fruition this session of Congress, it also seems certain that proposals embodying their major elements will be enacted within the next five years. The question is no longer whether there will, or should be intervention in health services to monitor care--but who will intervene and what methods will be used.

Much of the proposed legislation for reorganizing the health system or altering its financing tacitly assumes that either we have ready methods of quality assessment or can rapidly put together the technology, skilled manpower and data base needed for evaluation on a national scale. Of course, this is not the case. Pragmatic health services evaluation is a relatively new field and one that is in the process of developing and testing methodologies. There is a critical need for coordinating efforts to develop evaluation techniques, to do comparative testing of different methods of evaluation and to develop a cadre of trained social scientists, physicians, and allied health workers to carry out evaluation efforts.

This morning I would like to briefly review selected studies which have employed specific morbidity conditions as a means of evaluating health services; describe the "tracer" method that we have been working with at the Institute of Medicine, and discuss some of the pitfalls that any method of health services evaluation faces. Lastly, I want to

emphasize the need for academic centers to develop health delivery settings that are pragmatic, that can be used as live laboratories for testing and teaching, and that--in part--can in the future be transplanted to the world outside academia.

In July 1969, we began at the Institute of Medicine to develop a method for assessing health-care status among different groups of the population. As you know, attempts to evaluate health care are faced with two handicaps at the outset--by the vexing question of what constitutes quality and by the technical problems inherent in specifying discreet and consistent measurement units. The variability in disease severity, record keeping, and organizational structure make evaluation of ambulatory care particularly complex.

Partly to over come these problems, we focused on the premise that specific health problems could offer a perspective for viewing health status and care, and could provide a strategy for scientifically analyzing

health systems. Health problems could become, in effect, natural "tracers" that would allow health-care evaluation to pinpoint the strengths and weaknesses of a particular medical practice setting or an entire health-service network by examining the interaction between providers, patients and their environments. They also would provide easily understood data to be fed back into the health-delivery system.

The use of specific morbidity conditions to analyze health services is not new. In a study of the medical clinic of a university hospital in the early 1960's, for example, Huntley analyzed charts for completeness of patient work-up and proportion of abnormalities that were not followed up. More than one fourth of the patients with a diastolic blood pressure of 100 mm HG or higher were given no special tests relevant to hypertension, and approximately one half of these patients had no diagnosis related to the cardiovascular system.

Other studies of interest include recent work by Dr. Robert Brook who is one of the speakers this morning.

* In a study of 296 patients with either urinary tract infection, hypertension, or an ulcerated lesion of the stomach or duodenum who were treated at an emergency room, Dr. Brook assessed five methods of evaluating health care. When the adequacy of the process of care was combined with judgements concerning outcome, Dr. Brook found that the quality of care appeared to be acceptable for only 27 percent of the cases.

* Ciocco and colleagues in a study in 1950 analyzed services provided to 3,200 ambulatory patients who were seen for the first time by 16 different medical groups. Utilizing case records as a source of data, they divided the diagnoses into 18 categories and evaluated the relations between complaint, diagnosis,

services and treatment and the physicians' training and experience. Marked variations among medical groups in the type and amount of service delivered were documented. After correcting for such patient characteristics as age, sex, and diagnosis, the investigators concluded that differences in the amount of training and specialty status of the physicians accounted for much of the variation in services among the medical groups.

* Dr. Morehead and her colleagues reviewed charts to evaluate neighborhood-health-center performance in delivering preventive health care. Her analyses did not encompass clinical management or follow-up of potential pathology, but reflected the adequacy of the basic history, physical, and laboratory data and preventive care for adult medicine, obstetrics, and pediatrics. Using the performance of the medical-school-affiliated outpatient department as a standard, the study rated the neighborhood health centers above the hospitals in adult and pediatrics and slightly below in obstetrical care.

The evaluation methodology developed at the Institute of Medicine differs from previous efforts in several critical ways. These include the manner in which health problems were selected and combined in sets; specification of criteria for care, and, in application, concurrent assessment of health professional, the community he serves, and the people to whom he delivers care.

We've called the sets of health problems tracers--after a concept we borrowed from the formal medical sciences. In physiology, for example, scientists use radioactive tracers to study how a body organ--such as the thyroid gland--handles a critical substance such as iodide. They measure how the thyroid takes up a minute amount of radioactive iodide and assume the organ handles natural iodide in the same manner.

In measuring the functions and processes of a health-care system, the tracers needed must be as discrete and identifiable

as radioactive iodine. They must be health problems that flow through the system--each shedding light on how particular parts work, not in isolation, but in the system. The basic assumption remains the same; namely, how a physicina or health team routinely administers care for a set of common ailments or how a system identifies high-risk, pregnant women will be an indicator of the general quality of care and the efficacy of the system delivering that care.

In our study, we have developed a set of six tracers, all common diseases treated by health-care systems. Three of the tracers--iron-deficiency anemia; middle ear infection, including hearing loss, and visual disorders--are appropriate for children while hypertension, urinary tract infection, anemia and cervical cancer are useful in assessing care provided to adults.

CRITERIA FOR TRACERS

The value--and reliability--of evaluating health services by tracers rests on the selection of the tracers and the development of minimal care criteria against which the tracers can be compared.

The following are characteristics for selecting morbidity conditions to be used as tracers:

+ A tracer should have a significant functional impact on those affected. Conditions that are unlikely to be treated or those which cause negligible functional impairment are poor choices.

+ Each should be relatively well defined and easy to diagnose in field and practice settings. Dermatologic conditions, for example, require highly skilled professionals to diagnose and are difficult to screen on a mass basis. In contrast, it is relatively easy to delineate persons with iron deficiency anemia.

+ Each should have prevalence rates that are high enough to permit the collection of adequate data from a limited population sample. If an adequate number of cases is not obtained, it is difficult to analyze important variables. For example, in comparing different organizations for providing care, evaluators must control for social and demographic characteristics of the patients.

+ The natural history of the condition should vary with utilization and effectiveness of medical care. Ideally, in evaluating a delivery system, the tracer conditions should be sensitive to the quality and quantity of the service received by the patient.

+ The techniques of medical management of each condition should be well defined for at least one of the following processes: prevention, diagnosis, treatment, and rehabiliation or adjustment. There is real danger in using

outcome studies if it is unclear whether the provider can intervene in the natural course of the disease.

+ The effects of socio-economic factors on each tracer condition should be understood. Social, cultural, economic and behavioral factors will introduce variations in the epidemiology of many morbidity conditions. The epidemiology should be relatively well understood. For instance, lead intoxication among children in urban areas is usually caused by the ingestion of flaking lead-based paint prevalent in slum housing. Thus, it is the ghetto based and not the middle class medical delivery system that is challenged to identify the population at risk and institute appropriate diagnostic, therapeutic and preventive measures.

When combined in sets, tracers provide a means of evaluating particular health services from two or more perspectives. For

example, by combining iron deficiency anemia and hearing loss--treatment for both of which includes screening and health education counseling--an evaluator can gain insight about a health center's performance in screening and counseling across the entire age and sex range of its patients. Similarly, in evaluating drug therapy for middle ear infections and hypertension, we gather information about a range of drugs used in a total service population.

Two primary purposes of evaluation are: to support good medical practice by identifying its efficacious and efficient elements, and to indicate areas of practice in need of improvement. In both instances, the results of the evaluation must be fed back into the system at the point of delivery so that the persons responsible for managing the health program can use the results of the audit to institute change in the delivery services.

Combining analyses by the set of six tracers developed in this study with census data and simple demographic information,

basic strengths and deficiencies in specific aspects of a health care program can be identified, leading, where necessary, to changes in the organization and delivery of services. For example, in a hypothetical--although not farfetched--situation in which 25 percent of an enrolled high-risk population has not been screened for hypertension, only 11 percent of the estimated morbidity in the community has been identified, and significant differences exist between the care enrollees receive and the minimal care recommendations, the following steps to change services could be considered:

+ Institute community case finding efforts on a small population sample to determine the number of persons with high blood pressure not receiving care elsewhere in the community.
+ Restructure health center management procedures to obtain blood pressures on all enrollees considered at high risk.

+ Distinguish charts of patients with blood pressure above a specified level using age-sex criteria.

+ Discuss with the medical staff the results of the audit to consider use of structured medical record forms to obtain a minimal data base for all patients with hypertension.

+ Discuss with the medical staff alternative plans for therapy of hypertension in relation to the severity of the disease.

+ Specify medical criteria for patient follow-up.

+ Consider appropriate methods for administrative reorganization of follow-up procedures.

In order to field test the tracer method, we carefully indentified 2,600 children from 1,700 families representing a wide range of income levels in the District of Columbia. These families received care from one of a variety of medical practices: solo practitioners, fee-for-service partnerships, hospital out-

patient departments, and various group practices, some prepaid and others not.

In the course of the study, we put together a team of health professionals and examined the children ourselves. We examined them in this test because we felt that the tracers we had selected could fix on the quality of care the children received but we weren't at all certain that their medical records would be complete enough to tell us what we wanted to know. We also wanted to check the care they did not receive; that is, we wanted in this test to see how many children we found with pathology such as a visual impairment--that the regular source of care did not find.

The analyses of our present field studies are not complete--but I can give you an indication of the kinds of things we expect to find and of how such findings might be translated into restructuring and improving health care.

Before starting the major field test of the tracer method, we pretested it on a small scale by examining the medical records in two clinics with excellent reputations. One is a small clinic with a highly structured record system and method of practice. The other serves a larger population and provides "good" care; it is not tightly organized, however, and maintains its records in the unstructured way common to most of the profession.

We chose just one health condition to look at--middle ear infection. It has excellent characteristics as a tracer. If not treated properly, the disease has a rather high potential for permanently impairing the hearing of children, so the outcome is measurable; in one study, for example, 17 percent of the children who suffered acute middle ear infection developed a significant hearing loss--enough to handicap them in basic educational studies such as arithmetic and English.

Secondly, the diagnosis of the disease is relatively easy, and the prevalence is high, regardless of the child's social class.

Finally, care matters. Treatment with appropriate antibiotic drugs will clear up the infection, and the diagnosis and course of treatment--is generally agreed upon in the medical profession.

Using a set of diagnostic and treatment criteria, which were developed by practicing family physicians and specialists, we applied the tracer method to the two clinics. We found some striking differences.

This single indicator, middle ear infection, of course, did not compare everything the clinics were doing--it didn't look at radiology, for example, or physical therapy or immunization. It didn't even look at all phases of routine diagnostic procedures. But it did isolate some important indicators of how the physicians practice in each setting.

One of our criteria for minimal care for middle ear infections was evidence that the ear had been examined--hardly a criterion that can be argued. We found, however, that in more than 20 percent of the cases seen at the less structured clinic, the physicians had diagnosed middle ear infection without

physicians had diagnosed middle ear infection without ever looking in the child's ear. Or, if they did look, what they saw was apparently not important enough to write down. The highly structured clinic wasn't perfect; but only in less than seven percent of the cases they did not record the results of an ear exam.

It is generally agreed that in rare instances, are multiple antibiotics or fixed combinations of antibiotics indicated in the treatment of middle ear infections. Yet in the less structured clinic, we found that in nearly 45 percent of the cases, the physicians were prescribing 2 or more antibiotics. In the other practice, combinations were prescribed in less than two percent of the cases.

When these kinds of data are obtained on a set of six tracers which cover a broad age range of patients and a variety of services that are basic to delivering good care. We

believe it will provide the kind of information that a solo physician, clinic administrator, medical director, or consumer board needs to monitor care.

To be sure, there are dangers in this or any other method of evaluation which measures process and outcome of care; for one, a good evaluation, like a malpractice suit, may inflate demand and costs, such as the number of laboratory tests a physician orders. And, secondly, basing the evaluation on criteria for treatment assumes that the criteria matter and runs the risk of locking the profession into a rigid mode of practice.

We think these dangers are real. But there are potential offsetting benefits. If quality assessment uncovers things the providers should be doing and are not, it also uncovers things they shouldn't be doing and are--procedures that are expensive, unnecessary, useless or harmful.

If the treatment criteria--including looking in a child's

ear and taking his temperature--are those the professions agrees are minimal for care, and if they are periodically reviewed by the profession, the chances of stiffling innovation seem remote indeed. They may, in fact, encourage innovation by formalizing what we now know about treating certain disorders and measuring the health of the patient against the accepted practices. It would then be possible to assess innovation by results--a situation that is missing in most clinical practices today.

It is time to start building evaluative mechanisms into the process of delivering care and to compare different methods for health monitoring and evaluation. We must, however, be selective at the start. It would be folly to attempt to evaluate quality of care on a National basis now. We should begin with new delivery programs, and what setting could be more appropriate than HMO's under academic sponsorship. In these programs, the costs of comparing different evaluation methods could be subsidized and carefully

monitored, testing different structured record systems can be implemented with greater ease than in the private sector, and in these relatively sheltered programs, there is hope that tactics will be developed to learn how to use evaluative information to reorganize and adjust care to meet the needs of the people.

DRUG RESEARCH REPORTS
TRADEMARKS REG. U. S. PAT. OFFICE
1152 NATIONAL PRESS BUILDING
WASHINGTON, D.C. 20004
Wallace Werble, Editor & Publisher
Executive Assistant, Wallace Werble Jr.

Founded 1957 — $200.00 a year

"The Blue Sheet"

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Vol. 15, No. 37 September 13, 1972

SUPPLEMENT

EXTRA COPIES OF SUPPLEMENT AVAILABLE ON REQUEST
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HEALTH CARE QUALITY COMMISSION PLAN EXPLAINED IN HMO BILL REPORT; ARBITRATION PROCEDURE TO REPLACE MALPRACTICE SUITS ESTABLISHED

With this excerpt from the Senate Welfare Cmte.'s report on its HMO bill, "The Blue Sheet" concludes a two-part presentation of the most significant material in the document.

TITLE IV—COMMISSION ON QUALITY HEALTH CARE ASSURANCE

In developing the provisions related to the Commission on Quality Health Care Assurance, the Committee investigated in depth the existing mechanisms in effect in the Nation which seek to provide the assurance of quality medical care to the individual. The Committee was impressed by the peer review system developed by the California Medical Association (CMA) and by the dedication to quality health care demonstrated by the directors of the CMA peer review system. Those improvements in the quality of care which have been effected as a result of CMA reviews have been valuable and where effective seem to demonstrate what can be accomplished in certain instances by competent peer review groups.

Experts have cast increasing doubts on continued reliance upon current methods of quality assessment, control, and regulation. An increasing number of studies suggest that while the quality of many individual medical procedures and practitioners is high, the overall quality of care provided in the present system appears to be lower than is generally understoood. Slee, Lewis, Lembcke, Morehead, Trussell, and others [1] have examined the processes of medical care (i.e., the diagnostic and therapeutic measures through which medical care is

[1] C. E. Lewis and R. S. Hassanein, "Continuing Medical Education—An Epidemiologic Evaluation," *New England Journal of Medicine,* Vol. 282, No. 5, January 29, 1970; Paul A. Lembcke, "Medical Auditing by Scientific Methods: Illustrated by Major Female Pelvic Surgery." *Journal of the American Medical Association,* Vol. 162, No. 7, October 13, 1956: M. A. Morehead, *et al., A Study of the Quality of Hospital Care Secured by a Sample of Teamster Families in New York City,* Columbia University, School of Public Health and Administration Medicine, New York, 1964; and Ray E. Trussell, *et al., The Quantity, Quality and Cost of Medical and Hospital Care Secured by a Sample of Teamster Families in the New York Area,* Columbia University, School of Public Health and Administrative Medicine, New York, 1962. For the work of Virgil Slee and his associates see the various *PAS Reporters,* published by the Commission on Professional and Hospital Activities, Ann Harbor, Michigan.

delivered) and have arrived at two general conclusions. First, such processes often do not conform to predefined standards of "good medical practice." Second, there are wide variations in the rates at which laboratory tests, operations, or other medical procedures are performed between different providers. For example, Professional Activities Survey has discovered that the use of antibiotics after tonsillectomies varies from 2 percent in some of its member hospitals to 96 percent in others.[2]

These and other studies should not necessarily be interpreted to mean that the quality of medical care is universally low, but rather that it could probably be significantly improved through more widespread monitoring of the outcomes and processes of medical care. By measuring performance directly in terms of clinical outcomes, providers should be able to obtain frequent feedback on the efficacy of medical procedures and techniques so that they can more readily improve the quality of medical care that they provide.

The prepayment concept, when coupled with the assumption of financial risk by health care providers, provides incentives to reduce the services rendered to the lowest possible level in order to conserve resources and to stay within the income generated by premium revenues. Although this is a desirable effect of the capitation prepayment mechanism of purchasing services, in that it will provide strong incentives to reduce costs, it requires that there be strong and effective mechanisms to assure the quality of health care and that services of adequate quality and quantity are provided. The Committee believes that if it is to authorize the expenditure of public funds to initiate new forms of health care delivery, it has a responsibility to assure the American people that health services will be of high quality.

Evidence of the Need for the Commission on Quality Health Care Assurance—Health Care of Variable Quality

During the past year, the Committee has heard testimony indicating that the quality of health services is extremely variable, not only between regions of the country, but within a single region as well

At the present time the health care field has no standard setting capability of national scope.

The closest approximation to a national standard setting body which presently exists is the Joint Commission on Accreditation of Hospitals. The JCAH is a profession-dominated, profession sponsored private voluntary body which, in the words of its executive director, ". . . does not express any direct judgment on the medical care itself. . . . Accreditation implies that a hospital, at whatever level it is, is progressing towards improvement and following whatever recommendations we make."

The JCAH effort is voluntary, is limited in scope to hospitals, does not deal directly with the assessment of the quality of medical care and is not publicly accountable.

In the absence of quality standards, there is abundant evidence of great variation in the quality of health care services.

For example, in their as yet incomplete study of manpower utilization, the American College of Surgeons-American Surgical Associa-

[2] Professional Activities Survey Reporter, Commission on Professional and Hospital Activities, Ann Arbor, Michigan, September 2, 1969.

tion have determined that 30.7% of all practicing surgeons in the United States are non-certified by the American Board of Surgery. Although many of these surgeons are unquestionably dedicated, skilled physicians, some are under-trained, perform too few operations to retain their skills, and shouldn't be performing surgery given the large number of highly competent surgeons available in the United States.[3]

In a recent article in the *Federation Bulletin*,[3] Richard V. Ebert, M.D., professor of medicine and Chairman, Department of Medicine, University of Minnesota wrote:

> "Recertification is part of a complex structure of review of educational programs and examination of physicians designed to maintain quality in American medicine (Table II). The system is designed to produce a high standard of excellence in the training of physicians and to guarantee the American public high quality medical care. In general this has worked well. The birth of the American Board of Family Practice will ensure that virtually all physicians will be examined at the end of the period of graduate training. Many will be re-examined periodically.
>
> Recently it has become apparent that there are major defects in the system. Graduates of foreign medical schools may escape the rigorous training and attendant examinations required in United States medical schools. Many individuals taking graduate training either fail to take board examinations or fail to pass them. Most of these practice their specialty in any case. Whether all of them participate in continuing education we do not know.
>
> There is no question but that the development of the self assessment examination has been useful in making the physician aware of the deficits in his knowledge. The weakness of the method is the inability of educational planners to obtain accurate information regarding performance on the examination and the lack of stimulus to those physicians lacking interest in self education."

A study recently published by Dr. John Bunker in the *New England Journal of Medicine*[4] determined that the United States has twice as many surgeons in proportion to the population than in England and Wales. The same study showed that insurance coverage alone seems to increase the utilization of physicians' services; prepaid insurance plans (or group practice) tend to lower the rate of surgical operations performed; and fee-for-service payment seems to result in increased physician services. 1.6 times as many operations are performed on men, and almost twice as many are performed on women in New England as in Liverpool, England. The same author found that "on the order of four times" as many tonsillectomies are performed in New

[3] *Federation Bulletin*, 59; 6 June 1972.
[4] *New England Journal of Medicine*, 282; 3—Jan. 15, 1970.

England than in Liverpool, England, or Uppsala, Sweden. In summary, Dr. Bunker concluded that inter-regional differences in the performance of individual operations are "real, large and important; they are found in most of the common operations. Some of the differences may be related to various incidence of the conditions, but many are more likely to be caused by differences in the systems of medical care."

Osler Peterson et al. conducted an extensive study of general practice in North Carolina in 1953–54.[5] Among their findings, they concluded that the level of performance of the general practitioners studied was quite variable.

In summary, it is clear that effective quality control mechanisms do not exist in the health care field. There are neither standards nor fully developed methods for assessing the quality of care. This is of particular relevance to HMOs since the reimbursement structure in HMOs provides incentives to perform the fewest possible numbers of services, in contrast to the incentives inherent in the prevailing fee-for-service sector. The Committee believes, however, that the assessment of quality is a problem not unique to HMOs and HSOs, but is a topic which merits examination in all sectors of the health service industry.

This belief has been well substantiated through the hearings held thus far concerning HMO legislation. For example, current licensure laws in almost every state set minimum, usually one shot, standards, many of which are obsolete as exemplified by the American College of Surgeons-American Surgical Association figures quoted above.

The Committee believes that the Commission on Quality Health Care Assurance, authorized in title IV of S. 3327, will provide the badly needed impetus as well as an effective mechanism for developing the capability to assess and monitor the quality of health care on a national scale, and will have a major impact upon the appropriateness and effectiveness of health care services, both in and out of HMOs.

Development of New Types of Health Care Professionals

There is another reason for the development of the capability for evaluating the quality of health services. The emergence of highly organized systems of health care delivery will certainly encourage the development of new types of health care professionals, such as pediatric nurse practitioners, nurse midwives, and the varying forms of physicians assistants already emerging in different parts of the country. The Committee wishes to encourage the development of new forms of health professionals who will enable the physician to increase his efficiency and effectiveness, but recognizes the need for uniform, nationally applicable standards in a field where mobility among job categories as well as geographic mobility is a prevalent characteristic.

Need to develop new ways of measuring quality

Although standards relating to the training and qualifications of personnel, while variable from state to state, are well developed, standards relating to the process of health care and to the relationships between the process and the outcome of health care are poorly developed

[5] An Analytical Study of North Carolina General Practice 1953–54, *Journal of Medical Education*, December, 1956.

or non-existent. "Standards of medical practice" vary from community to community and from region to region.

The state of the art with regard to the measurement of the impact of health care services on the health of the population being served is rudimentary. The Committee is deeply concerned with the lack of technical knowledge or criteria to measure the results of health care services, and the consequent inability to accurately assess cost-benefit ratios. Such a capability is going to become increasingly important as the costs of health care services increase, and increasingly complex and sophisticated treatment alternatives evolve in medical practice. An understanding of the impact of health care upon the health of individuals being cared for will become increasingly urgent in the future.

The Committee recognizes the need to establish a national data base from which comparative statistics concerning the process and outcomes of health care can be drawn.

In the process of developing the proposal for the Commission on Quality Health Care Assurance, the Committee addressed itself to three sets of questions:

1. *Who should undertake the assessment and regulation of health care on the basis of outcomes; should it be the Federal government; the states; or should public regulatory authority be delegated to a private, provider-controlled body?*

The delegation of public regulatory authority to a private, provider-controlled body would appear to create an inherent and essentially insurmountable conflict of interest. Worthington and Silver have criticized the delegation of regulatory authority to the Joint Commission on the Accreditation of Hospitals (JCAH) under the Medicare program by illuminating the effectiveness of that Commission's regulatory programs.[6] In the case of health professional licensure, the work of Derbyshire, Bernstein, and others indicates that licensure (a mixed regulatory device in that it is a state regulatory mechanism with mandated provider control) has been a relatively ineffective system of quality regulation.[7] Another example is that while 20 percent of all hospitals representing 30 percent of hospital discharges voluntarily subscribe to the PAS system (operated by the Commission on Professional and Hospital Activities), very few of such hospitals utilize this medical data base to monitor the quality of care provided in their institutions. A further and final point is that despite the increasing technical feasibility of clinical outcome and process assessment, these techniques of quality assessment have not been applied on a systematic basis by any existing provider-controlled body.

The traditional systems of medical care delivery, rely upon the leavening influence of competition among providers. It seems unlikely that competitors could successfully regulate each other and still remain competitors.

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[6] W. Worthington and L. H. Silver, "Regulation of the Quality of Care in Hospitals: The Need for Change," *Law and Contemporary Problems*, Spring, 1970.

[7] Robert C. Derbyshire, *Medical Licensure and Discipline in the United States*, Baltimore, Johns Hopkins Press, 1969; and Arthur H. Bernstein, "Licensing of Health Care Personnel," *Hospitals*, Vol. 45, No. 3, February 1, 1971.

This does not mean that professional expertise is not pivotal to the implementation of quality regulation. Scientific and technical expertise is essential and in most cases it can only be supplied by health care professionals.

But, a quality regulatory system should be publicly accountable while relying upon professional expertise.[8]

There are also serious doubts about the constitutionality of delegating public regulatory power and grant-making authority to any private body.

This leaves the question of the appropiate governmental level for administration of the Commission's regulatory scheme. There are sound reasons not to rely exclusively upon the states. An effective system of quality regulation must be founded upon a solid understanding of health care problems, different methods of quality assessment, and alternative ways of delivering medical care. It seems highly overoptimistic to expect all 50 states to have this kind of technical expertise. Further, monitoring the quality of medical care on the basis of outcomes is not simply a matter of setting external standards at the Federal level which can then be enforced by personnel at the state level. Instead, an effective system of quality regulation involves making relatively sophisticated judgments about not only the necessity for further surveillance and/or sanctions, but about how to best help a provider improve its quality assurance system and the quality of care to be rendered.

Another disadvantage to the states independently carrying the lead in quality regulations without submitting to Commission review is that an effective system of quality monitoring should be an evolving, reactive one, in which the experiences of providers with different quality assurance systems in different parts of the country can be readily exchanged. Quality regulation carried out exclusively by states seem unlikely to achieve this kind of cross-fertilization.

In sum, while the states can play a role, any such role should at least be circumscribed and informed by concrete federal guidelines.

Thus the Committee believes it is advisable to locate the Commission at the federal level with specific areas of decentralized responsibility to the states.

2. *Should all providers be subject to the jurisdiction of the Commission; and if so should all providers (or all HMOs) be compelled or allowed to elect to submit to the jurisdiction of this Commission in return for support under the Public Health Service Act?*

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[8] An additional, secondary argument against delegation to a private, provider-controlled body is that no such body at present has a sufficiently wide scope to undertake this task. For example, Group Health Association of America (GHAA) represents HMOs, but not hospitals, group practices or other providers. The JCAH represents the American Hospital Association and organized medicine, but not HMOs, group practices per se, or other specific subsets of providers. The AMA and its associated county and state medical societies represent many physicians, but no institutional providers. A consortium of insurance carriers could perhaps be created, but the disadvantages of combining quality regulation with the third-party payor function are substantial.

Thus, no single provider-controlled group is sufficiently representative of providers to be the obvious condidate for the delegation of public regulatory authority in the quality area. However, much more important, even if such a body were put together, delegation of regulatory and grant-making authority to it seems highly inadvisable for the reasons discussed above.

There is no evidence that the quality of care provided by existing fee-for-service providers is any higher than that provided by HMOs. In fact, the few well-controlled studies that have been done indicate that the quality of HMO care is higher.[8a]

Barriers have prevented the widespread application of outcomes-oriented quality monitoring. Most of these barriers can be overcome, not only with the development of the HMO sector, but also with the evolution of more integrated non-HMO providers. Like HMOs, most hospitals and large group practices (i.e., multi-specialty group practices with ten or more physicians and single-specialty practices with five or more doctors) see sufficient numbers of patients to permit meaningful evaluation of the clinical outcomes of medical care. Similarly, many have an administrative structure and a record system upon which could be built an effective quality assurance system. In addition, most of the clinical outcome and process studies that have been carried out (i.e., those of Williamson, Brook, Brown, etc.) have been performed in a non-HMO setting. Thus, the technical feasibility of clinical outcome assessment in non-HMO providers is manifest.

In summary, since the quality of medical care dispensed by non-HMO providers is as likely to be significantly improved by increased outcomes monitoring as that provided by HMOs, and since such monitoring can be successfully carried out in non-HMO providers, particularly more integrated ones such as hospitals and group practices, all providers should be subject to the jurisdiction of the Commission.

While the arguments outlined above for inclusion of all providers under the Commission are strong, there are some convincing arguments supporting an "elective" approach which retains the possibility of including all providers. First, making outcomes-oriented quality regulation "elective" would protect the young HMO industry from unduly stringent regulation. This may be particularly important since past experience with outcomes assessment indicates that measurable outcomes are usually less satisfactory than had been expected by the providers involved.

A second argument for making outcomes-oriented quality regulation "elective" is that it makes it more difficult for providers to effectively cartelize the health industry through "capture" of the regulatory body. In the mandatory regulatory situation if existing providers gain control of the regulatory machinery and set quality standards in such a way as to make it difficult for new firms to form, particularly new HMOs, then entry into the industry can be effectively blocked. In contrast, in the "voluntary" regulatory situation new providers, including HMOs, admittedly unassisted under the Public Health Service Act, can enter the health industry, thus reducing the potential control of the medical care marketplace by existing providers through capture of the Commission.

[8a] See e.g., S. Shapiro, L. Weiner, and P. M. Densen, "Comparison of Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice Medical Care Plan", *American Journal of Public Health*, Vol. 48, February 1958; S. Shapiro, H. Jacobziner, P. M. Densen, and L. Weiner, "Further Observations on Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice Medical Care Plan," *American Journal of Public Health*, Vol. 50, September 1960; and Shapiro, J. J. Williams, A. S. Yerby, P. M. Densen, and H. Rosner, "Patterns of Medical Use by Indigent Aged Under Two Systems of Medical Care," *American Journal of Public Health*, Vol. 57, May 1967.

A third argument in favor of "elective" quality regulation, as to HMOs, is that explicitly tying preemption of selected existing state and Federal quality regulation measures to submission by HMOs to the jurisdiction of the Commission removes the possibility of application of a tiered system of quality regulation to HMOs. Such a step would retard HMO development since HMOs would then be forced to submit to the jurisdiction of this regulatory body as well as to existing state and other federal quality regulation. This problem is effectively avoided in S. 3327.

A fourth argument favoring the "elective" approach arises from considerations of the optimal regulatory "load" the Commission can bear. It the Commission might become swamped with work, all existing providers are immediately forced to submit to the jurisdiction of the Commission. This is particularly important because the Commission must administer an evolving program of regulation. At the same time, existing providers, who may not in the short run want federal assistance nor need preemption of existing state laws, nor perhaps be interested in receiving a "seal of approval" from the Commission, will have the time to adjust before submitting to its jurisdiction. Thus, if all existing providers do not at first elect the jurisdiction of the Commission, the latter's initial regulatory domain will thus be smaller and it will not be immediately faced with overwhelming regulatory problems and thus will be able to develop its expertise as its regulatory domain expands.

On balance, the committee felt the arguments in favor of the "elective" approach seem more persuasive.

3. Should the Commission be an independent regulatory body; what functions other than quality regulation, if any, should be included under the Commission's jurisdiction?

Aside from quality regulation what other substantive functions is the government performing now or is likely to perform in the future in relation to the health industry?

One such function is promotion of the industry, a task which is now primarily carried out by the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare. How can the government body, one of whose main tasks is to promote the health industry generally and to invest in specific providers, at the same time maintain the proper posture necessary to effectively monitor and regulate the quality performance of that same industry? For example, suppose that that government body had awarded sizeable grants, loans or contracts to assist an HMO in its planning and development. Would that same government body not be placed in a difficult position if the quality of care provided by that HMO appeared marginal?

This point—the undesirability of combining promotional and quality regulatory functions—was repeatedly made in the 1970 Congressional hearings on the formation of the Environmental Protection Agency, and was in fact one of the major arguments in favor of creating the EPA.[9] Examples cited included the combination within the

[9] See particularly the testimony of Russell Train, Chairman of the Council on Environmental Quality, and of Roy L. Ash, Chairman of the President's Advisory Council on Executive Organization.

Atomic Energy Commission of the mandate to promote the use of nuclear power with the responsibility to regulate radiation levels, the combination within the Department of Agriculture of the mission to promote agricultural production with the responsibility for regulating the use of pesticides, and the combination within the Bureau of Mines of the mandate to encourage the mining industry with the responsibility for sponsoring research to study the effects of mine acid discharges.

A second important function performed by the Federal government is that of third-party payor. This function is primarily carried out by two agencies of HEW, the Social Security Administration and the Medical Services Administration, which have the responsibility of administering the Medicare and Medicaid programs, respectively. Should the quality regulatory function be lodged with this third party payor function?

The third-party payor may be concerned about the quality of those services that he purchases for others, but he is likely to be less concerned than if he were purchasing them for himself. More important, in the case of SSA and MSA, these agencies seem to be monitored particularly closely by Congress on their ability to hold down costs. Hence, their main interest is likely to be the containment of costs, and if forced to choose between lower cost/lower quality and higher cost/higher quality, then these agencies would appear to be placed in a most ambivalent situation.

What has been the experience in other areas of Government with the third-party payor situation? One such example is the Federal programs subsidizing low income housing. In January 1971, the House Banking Committee issued a report in which it was charged that widespread abuses were occurring in such programs. The gist of the Committee's charge was that real estate speculators "had raked in huge profits selling patched-up dwellings to poor people while Federal appraisers looked the other way." [10] George Romney, Secretary of Housing and Urban Development, at first denied the charges and then admitted after meetings with a number of federal housing administration field personnel that the allegations were largely correct.

A second example can be drawn from experience with public welfare programs. In the welfare context, a single agency is usually responsible for both determining who is eligible for benefits and what services will be available to those who qualify. Thus, a welfare agency can reduce its costs by formally or informally tightening its eligibility standards. Piven and Cloward, in their recent book,[11] which reviews and analyzes public welfare systems in the United States since their inception, point out that in most cases this conflict between welfare costs and the quality of welfare services has been resolved in favor of reducing costs.

A third example is provided by the study of Holmberg and Anderson of nursing home care in the State of Minnesota.[12] They assessed the quality of nursing home care by comparing nursing homes on a

[10] *House Congressional Record*, February 8, 1971.
[11] Frances Fox Piven and Richard A. Cloward, *Regulating the Poor: The Function of Public Welfare*, New York : Random House, 1971.
[12] R. Hopkins Holmberg and Nancy N. Anderson, "Implications of Ownership for Nursing Home Care", *Medical Care*, Vol. 6, No. 4, July–August, 1968.

wide variety of input standards. One of their conclusions was that there was a strong positive correlation between the proportion of welfare patients in a nursing home and low quality care (as assessed by the input standards). Hence, this study, too, confirms the conflict of interest between the third-party payor function and the quality of services purchased.

Based on the above then, and given that the sole mission of the Commission is to ensure the quality of care, what location within the government will most facilitate its effective functioning? There are only two basic choices: an agency within HEW reporting to the Secretary or a regulatory commission independent of HEW.

There has been little research on this precise question. One analogue is the FAA which lost its independent status when it was moved to its present location directly under the Secretary of Transportation in 1966. Since that time it seems to have functioned about as effectively as it did before, although this point has not been rigorously established. Moreover, the FAA, unlike this regulatory body, was a well-established regulatory agency with a solid reputation and a defined constituency at the time of the shift.

As noted, there have been relatively few studies which have specifically addressed the question of what effect independence have on the effectiveness of regulation. One study that has is that of Haywood and Golemb [13] who reviewed the performance of state bank regulatory authorities and concluded that "effective regulation appears to be served when the regulatory authority is an independent unit." Conferees at the recent Brookings Conference on the regulatory process also strongly supported the independence of regulatory commissions. Their opinions on this subject were summed up by Noll [14] as follows:

> The conferees were unanimous in believing that independence is desirable for at least some types of regulatory decisions, if for no other reason than the credibility it gives to the agencies' objectivity. The conferees agreed that the "independence" of the existing independent agencies is to some degree illusory. The agencies are subject to congressional and executive pressures, partly because of the budgetary control exercised in these branches and partly because the President and the Congress are elected and therefore deservedly capture the attention of the regulators. Nevertheless, regulators do need the authority to make decisions that are contrary to the wishes of the other branches. This forces the offending branch to make a public show of reversing the agency through new legislation, rather than allowing the exercise of congressional or executive will to be surreptitious. The necessary institutional ingredient for independent decision making is a long term tenured appointment, which, regardless of the rhetoric or the organization charts, accounts for all of whatever independence the independent agencies enjoy.

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[13] Charles F. Haywood and Carter H. Golemb, "A Study of the Responsibilities and Powers Delegated to State Banking Authorities", unpublished manuscript, 1968. A summary of this study is published in the book by Noll cited in fn. 30.

[14] Roger G. Noll, *Reforming Regulation*, The Brookings Institution, Washington, D.C., 1971.

Thus, there are two arguments for the "independence" of the Commission. First, if quality regulation is important it should not be lodged within HEW where rigorous pursuits of quality assurance can be "traded-off" or compromised in the interests of cost containment and/or promotion of health sectors. Second, to the extent that conflicts between the Commission and SSA-MSA and HSMHA do occur, and they are inevitable and in some ways desirable, such conflicts can be resolved in a more public light than if the quality regulatory body is part of HEW where conflicts can be easily submerged. This is particularly important since the quality regulatory body would be a newly-created entity while HSMHA, SSA, and MSA are well-established powerful agencies with strong constituencies. Hence, if the quality regulatory body were to be located within HEW, even if it reported directly to the Secretary, it would be much less able to resist and compete effectively with HSMHA, SSA and MSA than if it were independent of HEW.

The Committee also believes that the independence of the Commission on Quality Health Care Assurance satisfies both of the basic criteria for the creation of an independent governmental agency set out by the President in his Message proposing the Environmental Protection Agency. The first criterion was that responsibility is divided among several agencies, but is not the primary function of any of them, and the other functions affect the agency's views of the regulatory issues. The second criterion, the President stated, justifying the creation of an independent agency was that a situation must exist in which the centralizing of authority in one agency would better enable that agency to make decisions about the activities of other agencies. The President stated that such decision making functions were better lodged in an independent agency than in an existing cabinet department. He reasoned that a cabinet agency, with multifarious non-regulatory responsibilities, might be regarded by other agencies as a representative of competing interests and constituencies and a promoter of its own programs at the expense of those other agencies. The Committee fully concurs with the statement of the President in respect to the Environmental Protection Agency and further believes that that logic applies with respect to an effective Federal presence regarding the regulation of certain federally assisted health services programs.

In sum then, the committee felt that the greater suasion that comes with "independence" is an essential ingredient in the effective functioning of the new quality regulatory body. Consequently, it should not be an agency within HEW reporting directly to the Secretary, but instead should be a regulatory commission independent of HEW.

Commission on Quality Health Care Assurance

The Committee has recommended that a Commission on Quality Health Care Assurance be established as an independent agency within the Federal government.

The mandated role of the Commission is threefold. First, it will have a strong role in setting standards for health care providers falling under its purview relating to the qualifications of personnel and adequacy of facilities.

The second major function of the Commission will be to gather data describing, in statistical terms, the process of health care in

various parts of the country. The Commission will develop the technology for relating health care process to outcome, with an emphasis on outcome. The Commission is further directed to establish statistically defined norms for health care practices. In instances in which significant deviation from the established norms is noted, the Commission is directed to investigate the reasons for the deviation. Persistent deviation from established norms in the absence of sufficient justification for such deviations can lead to the withholding or withdrawal of Commission certification from a provider.

The Commission is authorized to conduct what the Committee believes must be extensive research and development activities in establishing new health care standards, norms and outcome measurements.

An important aspect of the Commission's quality assurance programs will be the requirement and surveillance of adequate locally administered quality health care monitoring devices. These devices may take a number of forms. The exact nature of the quality of assurance system has been left by the Committee to the discretion of the Commission, but must satisfy Commission requirements with respect to reporting, data generating capability, and effectiveness. The Committee wishes to emphasize the importance of meaningful professional input into the evaluation of professional performance in the delivery of health care services. It wishes to express its desire that members of all health professions relevant to the provision of health care services in a particular system under review be given the opportunity to provide input into the specifications of the quality evaluation system.

A third major responsibility of the Commission is to monitor and enforce the meaningful and effective consumer disclosure provisions of the legislation. The Committee desires that information relating to fees and prices, range of services and composition of benefit packages, and the accessibility and availability of services including the location of facilities, equipment available, hours of operation, practitioners by type and location, and the nature of the plan's administration be made understandable to the consumer in order to satisfy the Commission's requirements.

The Commission on Quality Health Care Assurance is also authorized to issue certificates of compliance to those providers of health services, not affiliated with health maintenance organizations, health service organizations, or supplemental health maintenance organizations.

Such certification will be necessary in order to qualify providers for assistance under the Public Health Service Act, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, including any form of assistance under the provisions of S. 3327, except for the first two years of the life of the proposed law.

Providers of health care services other than those eligible for funds under the Federal programs described above may apply for certification by the Commission. In exchange, they will be eligible for preemption of state laws restricting forms of medical practice, corporate practice of medicine and other health care delivery patterns. In addition, they will be eligible for the Quality Health Care Initiative Awards authorized under section 1144 of S. 3327, intended to offset costs to

providers engendered by compliance with the Commission's requirements for Quality Health Care Assurance system operations. Federal malpractice reinsurance protection as provided in title IV of S. 3327, intended to increase the availability and decrease the cost of malpractice insurance and Federally supervised arbitration procedures for disputes arising out of the delivery of health care services will be available to certified providers of health care.

The Commission on Quality Health Care Assurance is to be composed of eleven members to be appointed by the President with the advice and consent of the Senate. Of the eleven members, four shall be consumers not related to the delivery of health care.

The Committee wishes to emphasize its intention that the evaluative and monitoring functions of the Commission on Quality Health Care Assurance have substantial and meaningful input from consumers of health care services. The Committee believes that the views of such consumers will be a substantive value in enhancing the ability of health care professionals to evaluate utilization patterns the overall quality of health care services.

The Committee fully appreciates the size and complexity of the Commission's mandate. It has therefore specified the functions of the Commission in great detail, and has attempted to outline the interrelationships among them. In the Committee's view, the Commission on Quality Health Care Assurance is the key element in S. 3327 which will assure that services delivered by providers eligible for assistance under the appropriate provisions of S. 3327, the Public Health Service Act, or the Community Mental Health Centers and Mental Retardation Facilities Act and Community Mental Health Centers of 1963 will be of high quality, and of an appropriate nature. It is intended that the development of the capability by the Commission to ascertain and describe patterns of health care practice, as well as to promulgate regulations concerning health care practices where those are appropriate, will succeed in defining the limits of acceptable health care practices and will help eliminate abuses of the health care delivery system on the part of providers and consumers:

The Committee is most sensitive to problems engendered by attempts on the part of the Federal government to impose regulations and standards upon an industry as complex and as intricate as the health care industry. Nonetheless, the Committee is deeply concerned about the lack of measurable parameters describing acceptable health care practices in the United States.

The Commission is expected by the Committee to interact in a meaningful way with the National Institute of Health Care Delivery whenever feasible. Would be both unwise from the standpoint of the Federal Government, and would subvert what little protection consumers receive through the experience of malpractice insurance policies.

S. 3327 contains many provisions which would alter existing regulatory mechanisms governing the provisions of health care services. It contains authority for the preemption of state laws, many of which provide for the licensure of personnel and facilities, in order to enable providers qualifying for assistance under the Public Health Service

Act and the Community Mental Health Centers and Mental Retardation Facilities Act of 1963 to implement new, innovative patterns of the utilization of facilities and personnel. The Committee recognizes that some regulation governing qualifications of facilities and personnel is necessary, and has given the Commission on Quality Health Care Assurance the authority to promulgate standards governing the qualifications of personnel, facilities, and equipment. It is hoped that such authority will be a step in the direction of simplifying the complex amalgam of state and local licensure requirements which currently exist.

It is not the intent of the Committee that the Commission engage in the setting of standards for, or the regulation of, the practice of medicine. The Committee recognizes the fact that at this time information is inadequate to enable such standards to be set on a nationwide basis.

The Committee has therefore recommended the adoption of an approach designed to improve our knowledge with regard to the process of health care delivery. Title IV of S. 3327 directs the Commission on Quality Health Care Assurance to put heavy emphasis on the development of criteria for internal quality assurances systems, intended to function within health maintenance organizations, health service organizations, supplemental health maintenance organizations, and other providers of health care falling under the purview of the Commission. The Committee wishes to emphasize that local quality assurance systems must have the cooperation and meaningful input of health care professionals in a local area. The Committee has intentionally left the exact nature of the quality assurance system to be determined through the deliberations and experience of the Commission on Quality Health Care Assurance. However, the Committee wishes to express its desire that in determining the composition of such local quality assurance systems, which comply with the criteria established by the Commission, the desirability of meaningful and substantial input from non health industry related consumers of health care services as well as members of the several health care disciplines such as dentists, nurses, and health administrators be considered.

In developing such criteria, the Committee intends that the Commission require the development of uniform data reporting systems enabling the Commission to gather information describing the nature of the process of health care as practiced throughout the country. This will make possible comparisons of the results of health care services in varying situations and in varying systems of health care delivery.

In meeting the requirements of the Commission, the Committee wishes emphasis to be placed upon the development of local mechanisms for monitoring and improving the quality of health care services, both in and out of health maintenance organizations. For that reason, the Commission will have great flexibility in defining criteria for local quality health care assurance systems. The Commission is authorized to reimburse providers a sum equal to 2 percent of their gross revenues in order to offset the expense inherent in establishing such a quality health care assurance system.

The Committee wishes to stress the importance which it places upon an adequate data evaluating and data reporting capability, in order to enable the Secretary of Health, Education and Welfare as well as the

Commission on Quality Health Care Assurance to intelligently and accurately assess the nature, extent, quality, and impact, of health care services in the United States.

Data reporting, in order to accomplish this goal, need not be burdensomely extensive, but it must be uniform and consistent.

Any internal quality assurance system must also have the capability for assessing and reporting the utilization characteristics of various providers of health care services, whether members of an organized system of health care delivery or not, if they fall within the purview of the Commission.

While the Committee recognizes the importance of a capability for measuring the qualifications of personnel, equipment and facilities, the process of health care, and the utilization characteristics as they apply to individuals and populations of patients, it wishes to emphasize its intent that the fundamental question which must be answered before determination regarding the appropriateness of various types of health care services can be made, is that of the impact of those services on the health of the people being served. For that reason, the Committee wishes to emphasize its desire that great stress be placed upon the development of the capability for measuring the outcomes of health care services on the health of the people being served.

The Committee recognizes the fact that the state of the art regarding outcome measurements is primitive at the present time, but hopes that through its other activities, both regarding the measurement of input, process, and utilization characteristics, as well as its activities in monitoring and compiling the results of malpractice arbitration disputes, the Commission can stimulate the creation of and develop a technology based upon outcome assessment. The Committee believes that a national approach with a rational centralized capability for generating and evaluating data, is the best way to achieve this goal. For that reason, the Commission on Quality Health Care Assurance is directed to conduct major research and development activities in the areas of the evaluation of health care services and of their impact upon the health of the individuals affected.

In addition to quality assurance systems the research and development activity of the Commission on Quality Health Care Assurance, must be designed to improve as well as assess the quality of health care. The Commission is directed to emphasize initially those illnesses which have a relatively high incidence in the population and which are particularly responsive to medical treatment rather than illnesses which are rare, or which are less responsive to medical therapy.

In addition to the above, the Commission is directed to assess the accessibility, availability and acceptability to health care provided by health maintenance and health service organizations, supplemental health maintenance organizations, and other providers of health care, and to contrast and compare various health care services systems.

If a provider of health care meets the requirements of the Commission on Quality Health Care Assurance, particularly those relating to the qualifications of personnel, facilities and equipment, and has installed a quality health care assurance system in compliance with the criteria developed by the Commission, the Commission is directed to issue a certificate of compliance to that provider of health care services.

The Commission is further directed to establish norms with respect to health care services, based upon the information generated by quality health care assurance systems, medical malpractice arbitration procedures and such other information as is available to the commission. These norms are to be statistical descriptions of the processes, utilization characteristics, and outcomes of health care services throughout the United States. The Commission is directed to establish statistical limits, within which acceptable health care practices lie.

If the Commission determines that a health care provider fails to comply with regulations established by the Commission, or consistently and significantly deviates from the norms established for health care processes, utilization characteristics, and outcomes, it is empowered to revoke or suspend a provider's certificate of compliance, after a hearing on the record during which the provider shall have full opportunity to justify his deviation from the norm in question.

Although the development of a capability for assessing the quality of health care services is the major mandate of the Commission on Quality Health Care Assurance, it has a second major area of responsibility. The Committee is concerned about the difficulty consumers experience in ascertaining the nature, scope, and coverage provided them under existing health insurance plans, and the difficulties they have in accurately evaluating the extent and quality of the health care they receive. For that reason, the Commission on Quality Health Care Assurance will have the responsibility to enforce consumer disclosure requirements contained in S. 3327.

Specifically, S. 3327 requires that a description of any health care plan receiving certification of Quality Health Care Assurance shall be published within 90 days after the establishment of such a plan.

The statute requires that each provider certified by the Commission on Quality Health Care Assurance furnish a copy of the plan description to every enrollee upon his enrollment in the plan and publish a brochure to the general public.

Penalties

The Committee considers it extremely important that the Commission have adequate authority to provide sanctions against providers who deviate from the Commission's requirements.

Whenever the Commission finds that a provider has significantly deviated from the approved Quality Assurance system or is engaged in practices which significantly deviate from national or regional norms, the Commission is empowered to hold hearings concerning the performance of that provider.

Such hearings shall be held in Washington, or at regional locations selected by the Commission on Quality Health Care Assurance in such a way as to minimize the inconvenience to those who wish to appear before the Commission.

If, after such a hearing, the Commission determines that the provider is not justified in deviating from standards or norms established by the Commission, it is empowered to suspend the certificate of compliance which had been issued to that provider. Providers who have had their certificates of compliance suspended for periods in excess of that determined to be reasonable by the Commission shall have their certificates revoked.

During the period of suspension of certificates of approval, the affected provider shall be ineligible to participate in grants, loans, loan guarantees, or interest subsidies under the Public Health Service Act and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

After revocation of the certificate of compliance, the Commission is authorized to make arrangements with the providers of health care who have had their certificates revoked for reimbursement for amounts received under the Public Health Service Act and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

In addition, criminal penalties are provided for willful or repeated violations of the requirements of the Act, fraud, and misrepresentation.

In promogating standards, rules, regulations, or norms, the Commission is directed to take into account the views of any provider or other interested party concerned with such rule, and to allow him adequate opportunity for comment. The Commission is directed to provide adequate safeguards, patterned after the Administrative Practices Act, in developing its requirements.

State Standards

While the Committee views the Commission as the final instrument for development and enforcement of standards of health care, it is of the opinion that the states, through a designated state agency, should be given the opportunity to develop health care standards so that local and other variations can be taken into account though the Commission would have to assure itself that such standards would at least be as effective and rigorous as those the Commission itself would otherwise institute. The Committee is aware, for instance, that disease patterns and treatment methodologies do differ, and appropriately so, from state to state.

An added factor in the Committee's decision to encourage states to develop their own standards is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development and health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards. The result is that these providers are more responsive to these standards when they have assisted in the development of the standards.

The Committee also feels that states, through their agencies, should be given the opportunity to enforce such standards as they or others may develop in accordance with an approved state plan submitted to the Commission. It feels that a three year period is sufficient time for such plans to be developed, submitted, approved by the Commission and made operative. The Committee further believes that the states should have the right of due notice regarding any decisions made by the Commission regarding its state plan or its implementation. The states are also entitled to judicial review of any and all such decision.

The concept of permitting the state agencies to develop their own standards and to enforce them, while giving the Commission evaluative authority over the state plan, is in keeping with the overall philosophy of the Committee. Where this is not possible, the Federal

government has the obligation to the public to assume such responsibilities.

Regarding the section requiring the states to develop and maintain exemplary programs for their own employees as part of their state plans, the Committee is of the opinion that the state should, itself, serve as a model for other employers and providers to emulate.

The Committee feels that while it is not common in the context of the health care system of this nation that a situation of clear and imminent danger would arise, the Commission should, upon demonstration that such danger exists, have at its disposal instruments for eliminating the danger. Accordingly, we have given the Commission, or in the event the Commission fails to act, the potentially injured party, the power to file for injunction or restraining order of the provider in question to the appropriate U.S. District Court.

Arbitration

The Committee on Labor and Public Welfare strongly endorses the arbitration provision of S. 3327 and believes such provision responds to the imperative needs for reform. Hearings on medical malpractice held by the Health Subcommittee documented the problems and interest for reform in medical malpractice litigation. The Subcommittee heard from a distinguished list of witnesses which included:

Wendell G. Freelund, Chairman, HEW's Secretary's Commission on Medical Malpractice; accompanied by: Eli P. Bernzweig, Executive Director, Commission on Medical Malpractice; Charles A. Hoffman, M.D., Private Practitioner and President-Eelect, American Medical Association, Huntington, West Virginia; Mrs. Ella L. Strother, Consumer Representative, Baltimore, Maryland.

Robert Coulson, President, American Arbitration Association, New York City.

Crawford Morris, Past-President, American Trial Lawyers' Association, Arter and Hadden, Cleveland, Ohio.

David S. Rubsamen, M.D., L.L.B., Consultant on Medical Aspects of Litigation, Berkeley, California.

Richard Carlson, Research Director, Institute for Interdisciplinary Studies, Minneapolis, Minnesota.

Medical malpractice litigation has become onerous to all of the concerned parties. The average time from the filing of the suit to the settlement of the claim is 4⅓ years. The protracted process in litigation is particularly difficult for both the plaintiff and the defendant. Arbitration will provide a convenient forum for an expeditious resolution of claims. The plaintiff's claim can be heard soon after the alleged incident of negligence and the defendant will not practice medical care under the shadow of a pending negligence suit.

The escalating costs of litigation will also be controlled under arbitration. The bulk of the costs are for attorney and court fees which are required costs for litigations. Arbitration would significantly reduce such costs since the forum may be held in any site convenient to the parties and court room procedures and process are not applicable. Under arbitration much more of the insurance dollar shall go to claimants with bona fide injuries rather than to costs of litigation.

Litigation of medical malpractice claims has not been an effective method to monitor quality health care standards. Very little data is

available concerning malpractice litigation. There is very little information available on the number of claims filed per year, the nature of negligence alleged, and the medical specialties involved and the background of the litigants. California has recently enacted a statute to get at this problem by requiring all successful claims of more than $3,000 must be reported to a state licensing body. This agency in turn must make an annual report with appropriate recommendations to the State legislature.

The Committee considers arbitration to be an efficient and effective method of resolving medical malpractice disputes as well as a most important monitor or health care practice. As a health care monitor, it is most important that arbitration be closely allied and related to the functions of the Commission. The mandate of the Commission includes the use of the findings in settlement or arbitration proceedings to evaluate health care and provide data for establishing criteria and standards for quality health care.

The Committee's view is that arbitration necessarily belongs under the aegis of the Commission on Quality Health Care and should only be made available to providers of health care who have certificates of compliance from the Commission. Since arbitration findings are to be used to develop standards which ultimately will be incorporated in the criteria for certification, providers should be certified to participate in arbitration. With certification, aribtration information will be an important feedback mechanism to the providers.

Under section 1209, each health maintenance organization may elect to offer its enrollees arbitration for medical malpractice disputes. The arbitration provision allows great flexibility for procedures to be fashioned by the providers of care and the enrollees. The Committee expects that the decision to provide for arbitration of medical malpractice disputes will be jointly developed by the health maintenance organization and enrollees. Such agreements are voluntary but would be binding on both the provider of care and the enrollee. The arbitration agreements between the enrollees and providers of health care shall require that all disputes not settled to the satisfaction of both parties be submitted to binding arbitration in order to gain the benefits of such programs.

The provider of health care who elects under section 1209 to provide arbitration must possess a valid certificate of compliance issued under section 1202(a)(3). The Committee strongly supports this requirement. This Committee conceives arbitration proceedings as a key monitor of health care practice. It is most important, therefore, that the provider of care possess a valid certificate of compliance from the Commission. Arbitration will be closely related to the functions of the Commission and will be viewed as part of the Commission's mandate to develop criteria for health care standards. Arbitration will not only provide an expeditious method to resolve medical malpractice disputes but also shall be an important means to assess and improve the quality of health care. In such a context the provider of care should be certified by the Commission so that arbitration will be an effective mechanism for ensuring better medical care.

Arbitration will provide a key element in the Commission's mandate to evaluate and develop standards for quality health care. The Committee expects that the Commission will develop a systematic

codification of all the findings from these arbitration proceedings and that such findings will be published at least annually. With such publication the consumers as well as the providers of care are free to judge what constitutes good medical care.

Such arbitration agreements must be valid in the jurisdiction which the agreement is made. Title IX of the United States Code shall apply to arbitration proceedings in those States where legislation does not provide for the finality of arbitration decisions or for arbitration agreements for controversies which may arise in the future. The following 26 States have modern arbitration laws, which do so provide: Alaska, Arizona, California, Connecticut, Florida, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, Wisconsin, Wyoming, Colorado, Nevada. The following 21 States have general arbitration laws which provide that agreement to arbitrate existing controversies *only* are valid and no *future* controversies: Alabama, Arkansas, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Carolina, North Dakota, South Carolina, Tennessee, Texas, Utah, West Virginia. Three States have no arbitration statutes: Oklahoma, South Dakota, and Vermont.

The Commission shall provide rules and regulations to achieve uniformity in the selection of arbitrators for such programs.

In the Committee's view, arbitration of medical malpractice disputes will provide a more effective and efficient means of settling malpractice claims and provide important data for the Commission in evaluating and developing standards for quality medical care.

This provision is a most important reform and should receive strong Congressional support.

The Need for Reform

Malpractice litigation has become the crucible for competing interests which reflect the striking changes occurring both in the medical and legal professions.

Medical malpractice litigation has failed to provide an efficient means to achieve a fair result for all concerned. It is a very expensive process and long delays before trial are the rule. In many cities, there are backlogs of several hundred cases with delays of up to three to six years. One estimate of the average delay between the filing and settling of a malpractice claim is 4⅓ years.

The cost to sustain such a system is becoming prohibitive. Estimated costs for malpractice litigation is now approximately $75 million a year. To sustain an effective suit and a defense, there must be extensive pretrial preparation. Arrange expert testimony and taking depositions of all the parties in litigation consume hours of time for physicians, claimants, and attorneys.

As a result of the high costs both pretrial and at trial, it has been demonstrated that for every premium dollar paid out in medical malpractice costs, only 10 to 20 cents ultimately is paid to the successful claimant. By contrast, for automobile accidents, 44 cents of each premium dollar is returned in the form of payment to the injured party.

Another result of the high cost is that attorneys are reluctant to take malpractice suits for minor claims. Firms specializing in medical malpractice often require the value of the claims which they are prepared to litigate to exceed $25,000 or $50,000.

The present litigation process is suffering from a crisis of confidence. There is serious concern that the quality of care is being adversely affected by the present system. More laboratory tests, more procedures for diagnosis, more X-rays and more consultations are being used. Then tests are done not on medical judgment but rather to prevent possible malpractice claims.

Not only are such procedures costly, but they may also be harmful as in the case of indiscriminate use of X-rays.

Over half of the respondents surveyed by the American College of Surgeons report they are increasingly practicing "defensive medicine", ordering more X-rays, laboratory tests, consultations, and records. Some doctors reported cutting out certain procedures altogether, and ceasing emergency room activities.

Escalating costs for litigation are reflected in the premium rates for malpractice insurance. Rates in California have quadrupled in recent years. Premium rates for 7,500 physicians in northern California were raised 13 percent only in the past 3 months. For certain surgical specialties regarded as high risk, such as neurosurgery, rates range from $4,000 to $15,000 per year. Despite the high premium rates, fewer and fewer companies are insuring and many physicians may soon be faced with no possibility for coverage.

Ultimately, the costs for this system are borne by the consumer. In California, it is estimated that 70 cents per patient per day of hospital charges currently go for malpractice insurance premiums. Yet, only 10–20 percent is ultimately returned in benefits to the successful litigant.

The growing concerns and complaints of both patients and physicians have resulted in many attorneys urging alternative approaches. A Federal commission on medical malpractice established in the Department of Health, Education, and Welfare has been studying the dimensions of the problem to determine possible solutions.

At the present time arbitration, broadly defined, is being used in two ways: 1) as a substitute for traditional litigation; and 2) as a screening process to eliminate unnecessary claims and to expedite the settlement of valid claims.

Arbitration of Medical Malpractice Disputes

Because of the general advisory nature of the screening panels, arbitration of medical malpractice disputes has been receiving increased acceptance as an equitable and binding procedure.

(*a*) *The Ross-Loos Medical Group.*—The Ross-Loos Medical Group of Los Angeles offers the earliest example of provider-patient agreements to arbitrate future malpractice claims. For more than 40 years subscribers to this prepaid health care plan have been required to sign a contract for future medical care, including an arbitration clause. From its perspective its experience with arbitration appears to have been good. Over 90,000 enrollees and 150 physicians are currently covered under the arbitration agreements. The Ross-Loos plan has resulted in reduced rates for malpractice insurance. Insurance rates

for the clinic are 80 percent less than comparable insurance rate for physicians in the immediate area. The experience at Ross-Loos has encouraged similar programs in California.

(*b*) *Southern California Demonstration Project.*—Eight Southern California hospitals initiated a demonstration project in 1969 utilizing arbitration as an alternative to litigation for resolving medical injury disputes. The project is being sponsored by the state medical and hospital associations in cooperation with participating hospital insurance carriers. Unlike the Ross-Loos program, this project represents the use of arbitration arising from present, not future, medical care.

Under this plan, when a patient checks into a participating hospital, he is asked to sign a medical admission form including an "Arbitration Option." According to the regulations employed under the project, either party may compel arbitration concerning malpractice or fees; parties may intervene; discovery is made under court supervision; lawsuits are stayed; the statute of limitations is not waived; joinder is permitted; and a hearing is required within ten days. All questions of fault and degree of injury are decided by an arbitration panel. The awards are made according to a schedule and are further based upon the concept of comparative negligence.

The "Arbitration Option," has apparently proved acceptable to patients. Over 195,000 patients have signed the admission forms since the program began in 1969. Only 181 have rejected the option at their hospital admission and, according to other terms in the hospital forms, a mere 8 others have revoked the arbitration agreement within 30 days after their release from the hospital.

(*c*) *The Kaiser Foundation Health Plan.*—The third and most recent development, initiated on a comprehensive basis on January 1, 1971, incorporates the use of arbitration as a substitute for traditional malpractice litigation in the Southern California Kaiser Foundation Health Plan. The program includes about seven hospitals and twenty out-patient clinics with a total membership of just under one million. Arbitration is provided for in a clause incorporated into the health plan contract.

LIMITATION OF CONTINGENCY FEES

The Committee on Labor and Public Welfare accepted an amendment to limit contingency fees of attorneys in those cases of medical malpractice disputes which go to settlement or arbitration within a health maintenance organization.

By so accepting the amendment, every attorney who represents a client in a medical malpractice dispute which shall go to settlement or arbitration as provided for under section 1209 and who receives compensation for services on a contingent or dependent basis must file with the Commission on Quality Health Care.

The Committee believes that limitation of contingency fees as incorporated in this section is crucial to countering the escalating costs of medical malpractice disputes and their settlement.

Many witnesses before the Department of Health, Education and Welfare Malpractice Commission and the first National Conference on Medical Malpractice testified that the ever-rising costs of malpractice suits are significantly related to fees of attorneys. Witnesses testified

that contingency fees as high as 50% are not uncommon in malpractice suits. Patients with bona fide injuries secondary to medical negligence have increasing amounts of their compensation going for the contingency fees.

The limitation of contingency fees on a scale to provide reasonable reimbursement to attorneys is necessary to alleviate rising malpractice suit costs and claims.

Dr. Mark Gorney of San Francisco, who represented the American Society of Plastic and Reconstructive Surgeons, testified to the HEW Malpractice Commission, "Many doctors point to the United States/Canadian border as an example of the irrationality of the present system. In Vancouver, the malpractice premium for a surgeon in the highest risk category is $35.00 per annum. In Seattle, a few miles south, it is 70 to 100 times that much. In much of Canada, it so happens, contingency fee arrangement is seldom used in malpractice cases and then it is strictly limited by the courts. Are we then to surmise that in identical areas medical standards on our side of the border are 70 to 100 times that bad?"

Joseph F. Donovan, Executive Director, Santa Clara County, California, Medical Society, told the Commission: "It is understandable that the plaintiff bar should be reasonably compensated for the risks that they take on a worthy case for a penniless patient. However, we do believe that some rule of order might be developed that would limit the percentage of the contingency when it reaches a certain plateau. Precedent for such scaling exists throughout the states in matters of *attorneys fees for probate.*"

Limitation of contingency fees is not a new approach. New Jersey, for example, and New York City now have systems limiting contingency fees on a scaled basis with the fee diminishing as the award increases.

Because of the effectiveness of arbitration in terms of both time and cost, the Committee believes limitation of contingency fees in this setting has considerable merit. Under the aegis of the Commission, arbitration and the limitation of fees provide an excellent opportunity for both the provider of care and the enrollee to control medical malpractice costs and provide just compensation to a victim of medical malpractice. The Committee is aware that contingency fees have been an important inducement to obtain representation for a poorer client. The mandate of the Commission will be to determine a limitation on fees which will not discourage legal representation but will provide adequate control to insure just compensation to the parties in malpractice disputes. The sliding scale on fees as enacted by several state and local jurisdictions are appropriate models.

The Commission has the authority to obtain complete information from the attorney concerning his agreement with his client for such compensation. The Commission in obtaining the necessary information and data from attorneys who file their retainer agreements with the Commission shall develop a system to control contingency fees which would be fair and equitable to the client and the attorney as well.

The Committee recognizes the need for confidentiality of such retainer agreements and therefore such a provision is included. Information on such agreements may only be divulged upon written order of the Chairman or the General Counsel of the Commission.

Summary

In the Committee's view, limiting contingency fees in arbitration proceedings is a sound approach to a difficult problem. The Commission shall be responsible for monitoring all findings of the arbitration or settlement proceeding and the corresponding contingent fee arrangements of the attorneys and their clients. An excellent opportunity is provided the Commission to evaluate the entire process and establish important criteria and standards in this area. It will not be an unreasonable burden on attorneys to file such statements with the Commission. There must be an efficient system devised to relate all findings to the Commission on medical malpractice disputes. Contingency fee statements could be part of the same data gathering process to be filed with the Commission.

Because the Commission shall have such an important role under this provision, it is most important that arbitration and the limitation of contingency fees be available only to those providers of care who have obtained a certificate of compliance from the Commission. These provision are closely related to issues of quality health care and, therefore, are programs to be provided only to those who have obtained the certificate of compliance.

The Federal Medical Malpractice Reinsurance

A key result of the current medical malpractice crisis has been the escalating costs for medical malpractice insurance. Premiums for medical malpractice insurance have continued to rise dramatically as the incidence of claims increased and the costs increased. As Crawford Morris, an attorney and a recognized authority on malpractice noted in his statement filed with the Senate Subcommittee on Health, medical malpractice insurance is becoming more and more difficult to obtain at any price, and is becoming more and more unprofitable to the private insurance industry. He cited an example of the difficulty a hospital had in obtaining such insurance and finally did so at a premium in excess of half a million dollars per year. In many circumstances, policies must be cancelled and insurance withdrawn to prevent continued losses. Mr. Morris cited the medical malpractice insurance policy as a "vanishing American" and raised serious questions about the need for reform.

At the First National Conference on Medical Malpractice, sponsored by the American Osteopathic Association, in February of 1970, representatives of the insurance industry pointed out that the serious problem in malpractice insurance was lack of reinsurance companies to share and spread the risks. In the field of reinsurance, the companies handling malpractice insurance are in need of the most support. It was suggested that if reinsurance support could be obtained from the Federal Government, more companies would be attracted back to the medical malpractice market and rates could conceivably be reduced.

Dr. Edward A. Johnson, President of the American College of Hospital Administrators, testifying before the Department of Health, Education and Welfare Commission of Medical Malpractice, strongly recommended the need for a new approach in reinsurance for medical malpractice. He urged the establishment of a new centralized mechanism for reinsurance which could improve and stabilize practices in medical malpractice insurance.

Dr. Mark Gorney of the American Society of Plastic and Reconstructive Surgeons also told the Commission that malpractice insurance should be more readily available and that if necessary the Federal Government can play an increasing role in this area as in the delivery of health care.

Establishing a Federal program for reinsurance in the medical malpractice area is analogous to other Federal insurance and/or reinsurance programs, as, for example, the Federal Deposit Insurance Corporation. The Federal Government has also acted as a reinsurer for State and private insurers offering property insurance to businessmen in riot areas, where it had previously been impossible for them to obtain coverage at reasonable rates, if at all. Congress, by passing the Housing and Urban Development Act of 1968, utilized existing State and industry insurance structures to provide protection from catastrophic loss to insurers who participated in state-wide plans.

The Committee on Labor and Public Welfare endorses the Federal reinsurance program under this bill. The reinsurance program responds to the serious need for stability in the medical malpractice insurance area. The Commission on Quality Health Care will administer the federal medical malpractice reinsurance program. The Commission will make medical malpractice liability reinsurance available to primary insurers for those providers of care who hold valid certificates of compliance under Section 1202. Reinsurance will be provided to those providers of care who have established and maintained quality of care standards consonant with the directions of the Commission on Quality Health Care. A majority of the Committee believes the Federal reinsurance program should benefit those providers of care who are practicing quality medicine.

In the Committee's view, it is apparent that a critical factor in the current instability in medical malpractice insurance is the lack or narrow base of support for reinsurance. To be sure, the process of malpractice litigation and the contingency fee system have been factors in the excalating costs to the insurers. But reinsurance problems have had insurers to cancel or withdraw medicine malpractice insurance for entire states, localities or individual practitioners. By establishing a Federal reinsurance system of support and controls stability and reduced costs should result to more providers of care who shall qualify by obtaining a certificate of compliance. Such a program has several Federal analogues and would be a most important Congressional response for needed reform in an area of critical concerns to the providers of health care and primary insurers.

A key concept of the bill is the issue of quality health care incorporated into the Commission whose mandate is to monitor and evaluate current health care practices and develop and establish criteria and standards of quality health care. A majority of this Committee believes reinsurance should only be provided to those providers of health care who comply with standards promulgated by the Commission. Reinsurance in the context of this legislation should not underwrite providers who are not practicing quality medical care and hence are frequently used successfully for medical negligence.

The Committee emphasizes that the Federal reinsurance program is applicable not only to primary insurers but also to those providers of care who self-insure.

The Committee endorses the basic authority given to the Commission to arrange for appropriate financial participation and risk sharing in the reinsurance program by insurance companies or other insurers. Initially, the Commission is given the authority to make reinsurance available to cover liability for amounts over $25,000 but not exceeding a million dollars per occurrence. The Committee believes that the Commission must have the flexibility to change the limits if it is determined feasible to extend the reinsurance program to cover amounts less than $25,000 or more than a million dollars.

The Committee strongly endorses this provision and believes that a Federal reinsurance program for medical malpractice insurance will be a most important element in stabilizing insurance costs in an equitable and cost effective way.

The program authorized is similar in many respects to other federal reinsurance programs. The Commission on Quality Health Care shall provide a most effective mechanism to create and administer such a reinsurance program in tandem with its other health care functions. The reinsurance program is another important approach in this legislation with arbitration and limitation of contingency fees to stabilize, improve and reform the critical area of medical malpractice. This reinsurance provision merits strong Congressional support.

DOMINICK SAYS CMTE. MAJORITY ERRED IN DOWNGRADING FOUNDATIONS; FORECASTS PERPETUAL GOVT. SUBSIDIES FOR HMOs SET UP UNDER BILL

I. Introduction

While there is not universal agreement that this country's health care delivery system is "in critical condition", nearly everyone agrees that improvements are needed. Health care is sickness, rather than prevention oriented; it is too expensive; it is uneven in quality; and good care is inaccessible to too many people. The health maintenance organization concept has been proposed by many as a solution to these problems, and indeed, it has considerable promise.

But "health maintenance organization" is a broad and relatively untested concept. Accordingly, the way in which it is defined for the purposes of determining what types of organizations are eligible for federal assistance is of critical importance. This is particularly true in view of the fact that this legislation would authorize federal expenditures totalling more than $5 billion over three years. (HEW's total health budget for fiscal year 1972 was about $17.6 billion. I feel S. 3327 defines "HMO" in a way which would restrict, rather than maximize, innovation and competition in developing better methods of health care delivery, and thus would limit the HMO concept's potential for dealing with the problems to which Congress is seeking solutions.

I have reservations about other features of this bill. In addition to massive support for reorganization of the health care delivery system, it provides for a permanent mechanism to finance health care. I think the financing of health care for those who are unable to pay should be dealt with in separate legislation. There are several national health insurance proposals pending in the Congress which are addressed specifically to that issue. I think the development of a more efficient delivery system is a formidable task which this legislation would be more likely to accomplish if it were addressed to that alone.

The bill's ambitious attempt to control the quality of health care through establishment of an independent "Quality Health Care Commission" with broad powers to establish and enforce uniform national standards raises several issues which concern me. Among them are the inhibiting effects on peer review-type quality assurance systems; insensitivity to varying conditions and needs in different geographical regions; and burdensome reporting and record-keeping requirements imposed on health providers by still another federal bureaucracy in Washington.

I am not satisfied with S. 3327 as reported, and hope it can be improved on the Floor. I voted to report it favorably because, although I disagree with its approach, I agree with its objectives—to improve the quality and accessibility of health care, and to reduce its cost. This is the first legislation which attempts to meet these difficult problems head on. Some of the solutions it proposes are imaginative and realistic—particularly the "health service organization" and "area health education center" concepts for rural areas in Title II.

II. The Definition of "HMO"—Exclusion of Foundations

The HMO concept has been broadly defined by the Executive branch, its essential elements being: (a) provision of comprehensive health services (emergency care, in-patient hospital and physican care, ambulatory physician care, and out-patient care); (b) to a defined enrolled population; (c) on a prepayment, rather than a fee-for-service basis.

The theory, and it appears to be supported by available evidence, is that such a system can reduce the cost, improve the quality, and increase the accessibility of health care by giving physicians incentives to stress preventive care and to increase efficiency. Such incentives derive primarily from the fact that an HMO is required to live within a predetermined budget, and its physician and other professional members bear the risk if the cost of services exceeds prepayments.

A wide variety of organizational forms can meet these criteria. These are the basic criteria used by the Department of Health, Education and Welfare in making grants to 110 HMO applicants for planning, development and feasibility studies. The 110 grant recipients include group practices, medical society foundations, hospitals, insurance companies, and others.

Title I of the bill, Part A, authorizes $1.025 billion for grants and loans to HMO's for planning and feasibility, initial development, construction, and initial operating costs. Section 1101 of Title I sets out some 18 conditions which an HMO must meet in order to qualify for assistance. One of those conditions is that an HMO's services must be provided "directly through its own staff and supporting resources or through a medical group or groups." "Medical group" is defined (Sec. 1101(3)) as a "partnership or other association or group of health professionals" who, among other things: (a) "as their principal professional activity" provide services as a group to an HMO; (b) pool their income and distribute it according to a prearranged plan; and (c) jointly use medical records, equipment, administrative staff, and health personnel.

The effect of the foregoing provisions is to exclude from eligibility foundations or other groups of physicians who practice in an individual rather than a closed panel group practice setting. The clear intent is to limit planning, development, construction, and operating support to one specific type of delivery model—closed panel prepaid group practice. Individual practice type organizations, including foundations, could qualify for support under Part B of Title I—"Supplemental HMO's"—which defines HMO consistent with the broad definition used heretofore by HEW. But unfortunately, "Supplemental HMO's" would be eligible only for funds left over at the end of each fiscal year after all applications from HMO's qualified under Part A of Title I had been funded (see Sec. 1108). The result is that Part B, an amendment adopted in Committee, has at best only symbolic significance—individual practice type HMO's would receive trivial, if any, federal assistance under Title I. Moreover, the symbolic significance would be adverse. Individual practice HMO's would be branded as a clearly inferior method of health care delivery.

Under the closed panel group practice model, a group of physicians and health professionals practice together in one facility and treat only patients who are enrolled in a plan entitling them to receive all

of their medical care from the group. The Kaiser-Permanente Plan is the prototype for this model. Foundations formed by medical societies or other groups of physicians operate differently. The member physicians continue to practice in individual or small group settings, rather than as one group in a single facility. Member physicians may continue to treat patients who are not enrolled in the HMO plan, and may be reimbursed on a fee-for-service basis by such outside patients. The important thing is that a foundation or other type of individual practice organization can satisfy the essential elements of the HMO concept: they provide comprehensive services to a defined population on a prepayment, rather than a fee-for-service basis; and, their member physicians are at risk if the cost of services exceeds prepayments.

While it is true that an individual practice-type HMO cannot offer its enrollees the advantages of "one-stop care" provided by a closed panel group practice type HMO, it can guarantee continuity of care, which is the most important characteristic of services provided in one facility. Continuity of care can be assured through a central record system shared by all of the member physicians, and through which all patient referrals would be made. Nor would enrollees in individual practice type HMO's make any sacifices in terms of quality of care. Foundations have been instrumental in improving quality through strong peer review mechanisms. Under some existing foundation plans, substandard care is reported to state medical licensing boards who have the power to revoke an offending physician's permission to practice in the state. Any argument that to make foundations eligible for the same assistance as closed panel group practice HMO's under this bill would be to compromise quality of care, quickly evaporates when exposed to the fact that foundation type HMO's would also be subject to the jurisdiction of the Commission on Quality Health Care Assurance proposed in Title IV. The Commission would have authority to promulgate and enforce specific minimum quality standards for all providers receiving assistance under the Act.

Individual practices HMO's offer advantages closed-panel type HMO's cannot. The most obvious of these is the wide range of physician choice available to enrollees. This is important to many patients, particularly the elderly, who have long-established relationships with particular physicians. Many patients, faced with a choice of traveling to a closed panel HMO located in a distant facility where all services are provided by a limited number of physicians, or continuing to see a private practitioner on a fee-for-service basis, would elect not to enroll in the HMO. On the other hand, if a foundation type HMO plan were available, such patients could enroll in the plan, pay a fixed annual premium, and continue to see their regular physicians for all services they are qualified to provide. Similarly, most physicians prefer to practice in an individual rather than a group practice setting. The fact that after many years of existence, closed panel group practices have not grown appreciably in popularity (about 90% of all patients are treated by individual practitioners) is good evidence of this.

One of the most difficult and urgent medical care problems in this country is the maldistribution of physicians and health personnel which leaves residents of rural and inner city areas without access to

good care. Witness after witness testified that the closed panel group practice HMO model could not effectively deal with this problem in rural areas. The thrust of their testimony was that since there is a physician shortage in rural areas, it would be unwise not to utilize all existing resources—i.e., individual practitioners in widely scattered small towns—in dealing with the problem. This was based partially on the recognition that development of HMO's depends on acceptance by physicians, and that many individual practitioners would not be disposed to abandon their practice and join a closed panel group practice. Accordingly, Title II of this bill would authorize support for Health Service Organizations outside of metropolitan areas. The definition of HSO differs from the definition of HMO in Title I only in that a wide variety of organizational forms, including foundations, would qualify for assistance as HSO's.

The argument that all available resources should be utilized to improve the accessibility of medical care applies with equal force to underserved urban areas. There is ample testimony in the hearing record on this point. It is unlikely that many closed panel group practice HMO facilities would locate in areas accessible to poor inner city residents. Physicians and their families find the environment undesirable. Experience with health manpower legislation demonstrates that this problem cannot be overcome with purely financial incentives. Further, closed panel group practice HMO's located in these areas could not survive economically without massive government subsidies. A citywide foundation type HMO would include individual practitioners already located in the inner city areas, and arrangements could be made for other physician members to spend a portion of their time treating patients in those areas. This has been proposed by George Himler, M.D., President of the New York State Medical Society. He says that even if we expanded our supply of physicians by 50%, deprived areas would realize virtually no benefit because of the reluctance of physicians and other health professionals to practice in such localities. He suggests that the foundation model is "a unique and ideal catalyst" for increasing the accessibility of medical care in the inner cities. I think it would be unfortunate to ignore an opportunity to deal with this problem by foreclosing foundation-type HMO's in urban areas from Federal assistance under Title I.

This bill assumes that closed panel prepaid group practice is the ideal organizational form of health care delivery and that further innovation is unnecessary. For reasons I have already stated, that assumption is questionable. But insufficient evidence is available to settle that issue now. We have had relatively little experience with the prepaid group practice model, and little, if any, experience with a model which meets all of the additional conditions specified in this bill. Under these circumstances, the most prudent course would be to expand federal assistance for development of HMO's only after the 110 experiments funded by HEW have become operational and the data derived from them has been carefully analyzed. Only then could we make intelligent decisions as to how much additional assistance is warranted, and which of the various organizational forms should be most encouraged. Nevertheless, Congress appears to be willing to substantially expand Federal assistance now. That being the case, I feel very strongly that it would be a serious mistake to restrict such assistance to one narrow organizational form as this bill would.

Moreover, the issue here is not which of many HMO organizational forms is ideal. We do not live in an ideal world. The real world—at least under a capitalistic system—is pluralistic. The issue is whether federal assistance for the broad and relatively untested HMO concept should be restricted to one specific organizational form, or whether it should extend to a variety of forms which satisfy the criteria essential to the HMO concept. I am not suggesting that the form of our health care delivery system should be dictated entirely by competition in the market place. If I were, I could not support legislation even approaching the massive Federal involvement in health care delivery which this bill represents. What I am suggesting is that a Federally assisted delivery system should make room for a variety of organizational forms in order to stimulate innovation and competition and to maximize freedom of choice for patients and physicians.

There is little testimony in the hearing record on this legislation supporting the exclusion of individual practice type organizations. On the other hand, there was strong testimony by HEW Secretary Richardson, representatives of the Association of American Medical Colleges, the American Association of Medical Clinics, the American Medical Association, the Health Services Research Center of the American Rehabilitation Foundation, the National Medical Association, and others, to the effect that in order to stimulate competition and innovation, "HMO" should be defined flexibly to include a variety of organizational forms—including the foundation model. The Administration's HMO bill, S. 1182, specifically provides that individual practice organizations would be on an equal footing in competing for HMO grant and loan funds. The pertinent part of the definition of HMO in S. 1182 reads as follows:

> "The term 'health maintenance organization' means a public or private organization which provides physicians' services (i) directly through physicians who are either employees or partners of such organization, or (ii) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis."

I am advised that under the HMO bill currently being considered by the House Interstate and Foreign Commerce Committee, individual practice type HMO's would be eligible for the same assistance as other types of HMO's.

I offered in Committee an amendment which would have eliminated the bias in Title I of S. 3327 against individual practice type HMO's by removing conditions such as pooling of income and joint use of medical equipment and health personnel, which are impossible for such HMO's to satisfy. All other criteria in the bill would have been left intact. The provisions regarding fixed sum prepayment by enrollees, quality control, consumer input, the mix of health professionals, the range of medical services provided, financial responsibility, risk bearing, open enrollment, community rating, etc., would apply equally to individual practice and closed panel group practice type HMO's. I intend to offer a similar amendment when this bill is considered by the full Senate.

III. Conflicting Approaches: Economic Viability Versus Permanent Federal Subsidies

The basic objectives of the Administration's HMO policy and this legislation are the same—to improve the quality, reduce the cost, and increase the accessibility of medical care in this country. But the approaches adopted to reach these objectives are vastly different. The Administration's approach is to stimulate innovation and competition in medical care delivery by providing Federal assistance for a wide variety of organizational forms which meet minimum criteria essential to the HMO concept. Consistent with this, the Administration's HMO bill, S. 1182, as well as its experimental HMO program, are based on the premise that after a limited period of federal assistance any given HMO will be economically viable—able to deliver medical services competitively without a continuing government subsidy.

The approach of S. 3327 is to establish a specific "ideal" delivery system designed and financed by the Federal government. Accordingly, its provisions are based on the premise that a federal subsidy will be available permanently; economic viability is not a criterion. Indeed, this approach has resulted in provisions which make it virtually certain that no HMO funded under this legislation could ever become economically viable, and therefore that a permanent massive Federal subsidy would be absolutely essential.

One of these provisions is found in Sec. 1101(2), which would mandate in specific terms that each HMO receiving assistance under Title I provide to all its enrollees a very broad range of services, including: physician services; in-patient and out-patient hospital services; home health services; diagnostic laboratory, and diagnostic and therapeutic radiologic services; preventive health services (including as a minimum family planning services, infertility services, and preventive dental care for children) and early disease detection services; emergency health services; payment for prescription drugs and continuous supervision of utilization by a clinical pharmacist who is a member of the HMO; medical social services; vision care; physical medicine and rehabilitative services, including physical therapy; mental health services; preventive diagnostic and medical and psychological treatment of the abuse of or addiction to alcohol or drugs; and such other services as may be required by the Secretary. Additionally, Section 1101 (1) (N) requires each HMO to provide to its enrollees extended care facility services and dental services as optional items for additional premiums. HSO's in rural areas under Title II are required to provide the same range of services, except that the Secretary can waive services which he finds an HSO is unable to provide.

This broad range of services would be mandated despite abundant testimony in the hearing record that to do so would inhibit the development of HMO's. Witnesses recommended over and over again that the benefit package should be flexibly defined to require only essential minimum services, and beyond that, whatever services were required by the enrolled population, and which could be furnished without making premium costs uncompetitive with other providers. The Administration's bill defines comprehensive health services as

> "All those health services which a defined population might reasonably require in order to be maintained in good health,

including as a minimum, emergency care, inpatient hospital and physician care, ambulatory physician care, and outpatient preventive medical services."

The hearing record indicates that few, if any, existing prepaid group practices—including the prototype for the HMO concept, Kaiser Permanente—provide the range of services which would be mandated in this bill. Representatives of the American Association of Medical Clinics and Group Health Association of America, who are involved in HMO type medical care delivery, testified strongly that the range of services mandated in S. 3327 were too broad, and would stifle HMO development by placing them at a severe disadvantage in competing with other types of providers, including the insurance industry. They felt that what services are provided beyond certain minimum services should be dictated by the ability of the HMO to provide them, and the ability of the enrollers to pay for them. This view was expressed by witnesses for the AFL–CIO, which represents probably the largest single group of existing and potential HMO enrollees.

The open enrollment and community rating provisions (Secs. 1101 and 1120), would require that HMO's and HSO's provide the mandated benefit package to each enrollee on a first come-first served basis, at one uniform rate. Applicants for enrollment could not be disqualified for health reasons. These provisions, in combination with the broad range of services mandated, would virtually eliminate the possibility that HMO's or HSO's assisted under this legislation could be able to compete with other forms of delivery. Only the wealthy could afford the premiums.

The bill therefore attempts to prop itself up with a massive permanent Federal subsidy ($1.825 billion over the first three years) which HMO's and HSO's would continue to receive after their eligibility for start up assistance expired. Section 1145(a) would authorize $1.225 billion over three years for capitation grants to subsidize the difference between premium costs and what enrollees could afford to pay. Each HMO or HSO could receive annual grants under this section equalling 25% of its total premium receipts for the preceding year. Section 1145(b) would authorize an additional $600 million over three years for similar grants to HMO's and HSO's which would otherwise have to raise premiums because the open enrollment requirement gives them a disproportionate number of high-risk enrollees. There is little doubt that almost every HMO or HSO would need the maximum allowable subsidy in order to survive.

I oppose this permanent financing mechanism for several reasons. First it would add tremendous cost to this legislation—almost $2 billion in direct subsidies alone. Its presence, by permitting imposition of requirements such as the broad benefit package which would be clearly unrealistic in its absence, would result in substantial additional indirect costs. Second, it amounts to piecemeal national health insurance, which I think should be addressed in separate legislation. By spending tax funds to subsidize premium costs for enrolles in HMO's and HSO's, it would discriminate against other Americans who receive medical care from non-HMO types of providers.

Finally, I believe it would increase the likelihood that this effort to improve our health care delivery system will fail. By contravening the principle of economic viability, the permanent financing

mechanism subjects the future of the HMO concept to the vagaries of the budget and appropriations processes. At some future point, Congress could be faced with the Hobson's choice of continuing to make large appropriations of general revenues to subsidize another faltering program, or permitting a very expensive investment of public funds to go down the drain. As I stated earlier, the development of a more efficient and accessible delivery system is in itself a very ambitious project for one piece of legislation. To the extent that this legislation attempts to do more, such as direct financing of health care for those unable to pay, its chances of improving the delivery system are diminished.

IV. The Quality Commission

Title IV would establish a new independent "Commission on Quality Health Care Assurance." While I agree that steps need to be taken to improve the quality of health care in this country, I don't believe a case has been made that another Washington-centered bureaucracy is the best answer. The Commission would have broad regulatory powers reaching virtually every aspect of medicine. It would promulgate standards with respect to physical facilities, the qualifications of physicians and other health personnel, and the mix of health professionals in medical groups. It would require providers within its jurisdiction to maintain "quality assurance systems" meeting specific criteria. It would promulgate and require compliance with statistical "norms" dealing with specific medical procedures, utilization rates, and actual health results.

The Commission's jurisdiction would extend to HMO's and HSO's receiving assistance under this legfiislation, and to all other providers receiving assistance under the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act. Other providers voluntarily submitting to the jurisdiction of the Commission would be entitled to Quality Health Care Initiative Awards in the form of annual grants equaling 2% of their gross annual receipts from delivery of health care services.

Standards and norms promulgated by the Commission would be enforced primarily through revocation of certificates of compliance upon which continued federal assistance would be conditioned. Participation in the new malpractice arbitration and insurance programs established under Title IV would likewise be conditioned on a certificate of compliance from the Commission. The Commission would have the power to require repayment of federal funds previously received by noncomplying providers, and to impose civil and criminal penalties, including fines up to $10,000 for each violation. Additionally, federal courts would be given jurisdiction to restrain conditions or practices by providers which pose an "imminent danger" of death or serious physical harm.

I am concerned that the foregoing broad powers of the Commission would, through over specificity, inhibit innovation in the development of peer review-type quality assurance systems. This criticism was made by witnesses for the Health Services Research Center of the American Rehabilitation Foundation, which originally proposed establishment of the Commission. Also, I think the uniform national standard approach of the Commission's regulatory powers would be insensitive

to varying local conditions and needs, and might result in the imposition of requirements which many providers simply could not meet. It is clear that the data and methodology necessary to establish specific quality control criteria are not available now, and probably will not be until after several years of intensive research. In the meantime, it would make more sense to leave the burden of quality control with state licensure laws and local peer review mechanisms, subject to monitoring by the Commission on a regional basis, and to limit the jurisdiction of the Commission to providers receiving assistance under this legislation.

The Commission would add considerably to the already burdensome paper work imposed on providers by various federal health programs, further driving up the cost of medical services. The Commission and the Secretary of HEW would be given unlimited discretion to require providers within the jurisdiction of the Commission to maintain detailed records and file periodic reports relating to all aspects of their health care delivery activities. Such providers would also be required to disclose basic benefit, rate, and quality indicators to enrollees and the general public, subject to close monitoring by the Commission.

Finally, I am afraid the Commission would be very expensive. The bill authorizes $285 million over three years for its research and regulatory activities. An additional $900 million is authorized for Quality Health Care Initiative Awards to outside providers who submit to the jurisdiction of the Commission, running the total to $1.185 billion over the first three years. The total cost over the first five years is estimated at $2.24 billion by the Health Services Research Center of the American Rehabilitation Foundation.

V. Conclusion

My views on this bill can be summed up simply this way: Each of its objectives, considered alone, is laudable and addressed to an important problem. But the prospects of achieving all of them at once seem to me to be unrealistic. Federal expenditures of this magnitude should not be exposed to such great risks. Its scope should be narrowed to the urgent problem of stimulating the development of improved health care delivery systems.

NSF AWARDS $95,000 TO STANFORD TO STUDY ANIMAL CHROMOSOMES; WIS. U. GETS $75,000 FOR RIBOSOME FUNCTION, ASSEMBLY RESEARCH

(Natl. Science Foundation Aug. 23 - 31 life sciences awards)

ALA. U. (Birmingham) -- $30,000 -- Thomas Andreoli, Transport phenomena in lipid bilayer membranes & isolated, perfused renal tubules.

-- $60,000 -- Tetsuo Shiota, Biosynthesis of pteridines & folate-like compounds.

ALA. U. (Tuscaloosa) -- $10,000 -- John Hardman, Translational & transcriptional terminal punctuation in E. coli tryptophan operon.

CALIF. U. (S-F) -- $50,000 -- Brian McCarthy, Organization & control of mammalian genome.

CALIF. U. (Santa Cruz) -- $10,000 -- Ralph Hinegardner, Sea urchin development & genetics.

CONN. U. -- $42,000 -- Dudley Watkins, Mechanism of insulin secretion.

HARVARD -- $37,215 -- Luigi Gorini, Regulation of gene expression in a biosynthetic pathway performed in vitro.

-- $18,143 -- Richard Berlin, Transfer of purines by erythrocytes to non-hepatic tissues.

-- $43,855 -- Fotis Kafatos, Cellular differentiation and specific protein synthesis.

-- $19,858 -- Henry Paulus, Multivalent feedback inhibition of aspartokinase in bacillus polymyxa.

-- $490 -- Bernard Babior, Travel to conference on metalloenzymes, Oxford, England.

HOPKINS -- $60,000 -- Curt Richter, Periodic manifestations in animals & man.

INSTITUTE FOR CANCER RESEARCH (Phila.) -- $25,000 -- Abraham Marcus, Regulation of protein & nucleic acid biosynthesis in germinating seed embryo.

MARINE BIOLOGICAL LAB -- $25,000 -- Albert Szent-Gyorgyi, Energy, entropy, quantum rules, cell division & cancer.

MICH. STATE U. -- $20,000 -- John Boezi, Studies of structure and mechanism of action of DNA-dependent RNA polymerase & ATP:RNA adenylyltransferase (poly A polymerase) from pseudomonas putida.

NEB. U. (Omaha) -- $21,200 -- Judith Ramaley, Adrenal maturation & fertility.

NEV. U. (Reno) -- $60,700 -- R. Allen Gardner & Beatrice Gardner, Psychobiology of two-way communication.

NM STATE U. -- $18,000 -- James Botsford, Physiological significance of tryptophanase in E. coli during normal conditions of growth.

NM U. -- $42,500 -- Sidney Solomon, Regulation of kidney in developing rats.

UNC -- $25,000 -- Edward Glassman, Chemical correlates of behavior.

ORE. U. (Eugene) -- $50,000 -- Franklin Stahl, Growth, mutation & recombination in bacteriophage.

PITT -- $43,000 -- Sarah Hopper, Deoxyribonucleotide, biosynthesis in mammalian cells.

PRINCETON -- $30,000 -- Walter Kauzmann, Physical chemical studies related to protein structure & behavior.

P&S -- $38,000 -- David Nachmansohn, Proteins in excitable membranes; properties & function in bioelectricity.

-- $59,400 -- Harry Grundfest & John Reuben, Mechanisms of contractile activity in muscle.

ROCKEFELLER U. -- $18,100 -- Martin Rizack, Cellular physiology of enzyme regulation.

S. FLA. U. -- $33,300 -- Stewart Swihart, Electrophysiological study of sensory discriminatory mechanisms.

STANFORD -- $95,000 -- David Hogness, Structure & function of animal chromosomes.

-- $708 -- Alan Blumenthal, Travel to NATO advanced study institute on DNA replication & cell membrane at Cortina, Italy.

SUNY (Stony Brook) -- $50,000 -- John Stamm, Cortical processes in learning & memory.

UTAH U. -- $49,900 -- George Edmunds, Higher classification of the emphemeroptera.

U. OF WASH. -- $15,000 -- David Deranleau, Geometry-specific charge & energy transfer interactions in proteins & polypeptides.

WIS. U. (Madison) -- $75,000 -- Masayasu Nomura, Structure, function & assembly of ribosomes.

WISTAR INSTITUTE -- $14,200 -- Elliot Levine, Molecular biology of cellular interactions.

YALE -- $29,200 -- Frederick Ziegler, Synthesis of indole alkaloids of biogenetic & chemotherapeutic interest.

NIH DIV. OF RESEARCH GRANTS STUDY SECTIONS PROJECT REVIEW MEETINGS

(Date, time, and location of DRG panel meetings to review grant applications)

Study section/Committee	Date	Time	Location of meeting
Pharmacology A, Dr. Lawrence Petrucelli	Sept. 6 to 9	9 a.m	Bethesda, Md.
Pathology A, Dr. William Savchuck	Sept. 7 to 8	8:30 a.m	Silver Spring, Md.
Communicative Sciences, Mr. Frederick Gutter	Sept. 9 to 11	8 p.m	Bethesda, Md.
Pharmacology B, Dr. Anne Bourke	Sept. 10 to 12	9 a.m	Do.
Developmental Behavioral Sciences, Dr. Bertie Woolf	Sept. 11 to 13	8:30 a.m	San Francisco, Calif.
Experimental Psychology, Dr. A. Keith Murray	do	9 a.m	Bethesda, Md.
Toxicology, Dr. Rob S. McCutcheon	do	8:30 a.m	Do.
Dental, Dr. Luis Angelone (acting)	Sept. 12 to 14	9 p.m	Do.
Hematology, Dr. Joseph Hayes, Jr	Sept. 13 to 15	7 p.m	Chevy Chase, Md.
Allergy and Immunology, Dr. Mischa Friedman	Sept. 14 to 16	8:45 a.m	Bethesda, Md.
Cardiovascular and Pulmonary Research A, Dr. Wendell Kyle.	do	8:30 a.m	Do.
General Medicine B, Dr. S. Stephen Schiaffino (acting)	do	2 p.m	Washington, D.C.
Genetics, Dr. Katherine Wilson	do	9 a.m	Bethesda, Md.
Neurology A, Dr. William E. Morris	do	9 a.m	Do.
Physiological Chemistry, Dr. Robert L. Ingram	do	9 a.m	Do.
Tropical Medicine and Parasitology, Dr. George Luttermoser.	do	9 a.m	New Orleans, La.
Virology, Dr. Claire Winestock	do	9 a.m	Bethesda, Md.
Visual Sciences A, Dr. Marie Jakus	do	9 a.m	Do.
History of the Life Sciences, Mrs. Ileen Stewart	Sept. 15	9 a.m	Do.
Biophysics and Biophysical Chemistry A, Dr. Irvin Fuhr	Sept. 15 to 16	9 a.m	Do.
Biophysics and Biophysical Chemistry B, Dr. John Wolff	do	9 a.m	Do.
Surgery A, Dr. Raymond Helvig	do	8:30 a.m	Silver Spring, Md.
Surgery B, Dr. Joe Atkinson	do	8:30 a.m	Do.
Population Research, Miss Carol Campbell	Sept. 15 to 17	9 a.m	Chevy Chase, Md.
Epidemiology and Disease Control, Mr. Glenn Lamson	Sept. 20 to 22	8:30 a.m	Bethesda, Md.
Computer and Biomathematical Sciences, Dr. Irving Simos (acting).	do	9 a.m	Do.
Reproductive Biology, Dr. Robert Hill	do	9 a.m	Do.
Biomedical Communications, Mrs. Ileen Stewart	Sept. 21 to 22	9 a.m	Do.
Bacteriology and Mycology, Dr. Milton Gordon	Sept. 21 to 23	8:30 a.m	Chevy Chase, Md.
Cardiovascular and Pulmonary Research B, Dr. Floyd Atchley.	do	9 a.m	Bethesda, Md.
Cell Biology, Dr. Evelyn Horenstein	do	9 a.m	Do.
Human Embryology and Development, Dr. Samuel Moss	do	8:30 a.m	Carmel, Calif.
Immunobiology, Dr. James Turner	do	9 a.m	San Francisco, Calif.
Medicinal Chemistry B, Dr. Thurman Grossnickle	do	9 a.m	Silver Spring, Md.
Metabolism, Dr. Robert Leonard	do	8:30 a.m	Do.
Microbial Chemistry, Dr. Gustave Silber	do	9 a.m	Chevy Chase, Md.
Molecular Biology, Dr. George Eaves	do	9 a.m	Bethesda, Md.
Neurology B, Dr. Louise Thomson	do	8:30 a.m	Do.
Visual Sciences B, Dr. Marie Jakus	do	9 a.m	Do.
Pathology B, Dr. James MacNamee	Sept. 21 to 24	8:30 a.m	Berkeley, Calif.
Biochemistry, Dr. Sanford Birnbaum	do	9 a.m	Bethesda, Md.
Medicinal Chemistry A, Dr. Asher Hyatt	do	7 p.m	Silver Springs, Md.
General Medicine A, Dr. Wilton Fisher	Sept. 24 to 26	8 p.m	Bethesda, Md.
Nutrition, Dr. John Schubert	Sept. 25 to 27	8:30 a.m	Do.
Physiology, Dr. Clara Hamilton	Sept. 28 to 30	7:30 p.m	Do.
Radiation, Dr. Robert Straube	do	9 a.m	Los Alamos, N. Mex.
Applied Physiology and Bioengineering, Mrs. Ileen Stewart.	Sept. 29 to 30	8:30 a.m	Bethesda, Md.
Arthritis and Metabolic Diseases Program Project Committee, Dr. Harold Davidson.	Oct. 2 to 3	9 a.m	Do.

Meetings to review grant applications are closed to public attendance, unlike advisory council meetings conducting any other business.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

October 26, 1972

TO: Members of the Council of Deans

FROM: Joseph S. Murtaugh

SUBJECT: Faculty Information

The attached is distributed to the membership of the Council of Deans as a matter of interest, and as a follow-up to the discussions last February regarding data developed from the AAMC Faculty Roster project.

It is important to note that the information used as a basis for the tabulations in the attached analysis was protected, in that the names and other identifying characteristics of individuals were retained in the AAMC files and not made available to NIH in providing data for this analysis.

It is our intent in the future to provide information which is more sharply focused on topics more closely related to the operational problems of medical schools and medical centers. Your continued support and cooperation in this project is appreciated.

jp

Profiles of U.S. Medical School Faculty
Fiscal Year 1971

This publication presents a series of national profiles of salaried medical school faculty. It covers the faculty's demographic characteristics, major areas of professional activity, recent employment history, sources of recruitment, and volunteer service. This summary will be followed by an in-depth medical school faculty report and an extensive set of basic reference tables covering these and other items in greater detail. It is expected that the information contained in these publications will be of significant value to those responsible for monitoring the biomedical, scientific, and professional manpower scene and for future program planning.

Data for these publications were derived from the roster of full- and part-time salaried medical school faculty maintained by the Association of American Medical Colleges (AAMC) under contract with the National Institutes of Health (NIH).

This analysis was prepared under the direction of Dr. Herbert H. Rosenberg, Director, Office of Resources Analysis, Mr. Wayne E. Tolliver, Chief, Manpower Analysis Branch, was responsible for the development and preparation of the report. Mrs. Carol M. Brown and Mrs. Dorothy F. Boykin assisted in the preparation of the report.

The Nation's medical colleges confront a steeply rising demand for faculty stemming from (1) the expansion of existing medical schools and the establishment of new schools, and (2) the extension in the scope of the traditional triad of education, research, and service. In the past decade, the number of full-time medical school faculty increased more than 150 percent—from 11,200 in Fiscal Year 1961 to 28,100 in Fiscal Year 1971. The AAMC and the NIH, in recognition of the growing problems in staffing the medical schools, instituted a medical school faculty roster project in 1966 to keep abreast of trends in faculty status, staffing patterns, and faculty activities. This publication presents selected highlights from the Fiscal Year 1971 faculty roster.

DISTRIBUTION OF FACULTY

Distribution of Total Faculty—Table 1.

The 28,452 full- and part-time salaried medical school faculty included in the Fiscal Year 1971 universe were distributed as follows: 51 percent in public medical schools and 49 percent in private schools; 96 percent in 4-year accredited medical schools, 2 percent in 2-year schools of basic medical science, and 2 percent in developing medical schools; 23 percent were professors, 23 percent associate professors, 34 percent assistant professors, 14 percent instructors, and 6 percent below the rank of instructor; 90 percent had full-time faculty appointments, and 10 percent had part-time appointments; 25 percent were biological scientists, 60 percent had clinical specialties, and 14 percent had other specialties.

Distribution by Sex—Table 1.

The medical school faculty were predominantly male—86 percent men and 14 percent women. The same proportions were in evidence for private and public medical schools, 4-year medical schools, and schools of basic medical sciences. In certain categories, men accounted for a significantly higher percentage of the total faculty—91 percent of the faculty in developing medical schools, 96 percent of the professors, 91 percent of the associate professors, 90 percent of the clinical specialists, and 91 percent of the mathematical and physical scientists. There were fewer women than men in every category except allied health where women accounted for 55 percent and men for 45 percent. Thirty-six percent of the behavioral sciences faculty were women. There was a relatively low percentage of women in the higher academic ranks.

Distribution by Citizenship—Table 1.

Nine-tenths (91 percent) of the medical school faculty were U.S. citizens, and 9 percent were foreign. These foreign citizens were very much in evidence in the lowest academic ranks where they ranged from 15 to 20 percent of the total. A significantly higher than average percentage of foreign citizens also appeared in the schools of basic medical sciences, biological science specialties, and private medical schools.

If the location of training is considered, rather than citizenship, the data show that 84 percent of the full-time medical school faculty were trained in the United States, and 16 percent were trained in foreign countries. The percentages trained in the United States and in foreign countries varied significantly according to the type of earned degree—M.D.'s, 82 percent and 18 percent, respectively; Ph.D.'s, 92 percent and 8 percent; and for those with both degrees, 64 percent and 36 percent.

Distribution by Type of Degree—Table 1A.

Faculty with the M.D. degree—Fifty-nine percent of the medical school faculty were M.D.'s—56 percent in public medical schools and 63 percent in private schools. Four-year medical schools had the highest percentage of M.D.'s on their faculty—60 percent compared to 38 percent in schools of basic

medical sciences and 46 percent in developing medical schools. The M.D.'s were well represented among the highest academic ranks—62 percent of the professors and 63 percent of the associate professors, as compared with 60 percent of the assistant professors and 55 percent of the instructors. The percentage of M.D.'s dropped sharply below the rank of instructor. Only one-half of the strict full-time faculty were M.D.'s; whereas, approximately three-fourths of the other full- and part-time faculty were M.D.'s. The lion's share of M.D.'s reported a clinical specialty; however, M.D.'s were very much in evidence in the biological sciences as well. More specifically, 86 percent of the clinical specialists, 17 percent of the biological specialists, and 3 to 5 percent of the specialists in other fields were M.D.'s.

Faculty with the Ph.D. degree—Ph.D.'s represented twenty-five percent of the medical school faculty—27 percent in public medical schools and 23 percent in private schools. Schools of basic medical sciences had the highest percentage of Ph.D.'s—45 percent compared to 37 percent in developing medical schools and 24 percent in 4-year medical schools. Most of the Ph.D.'s were in the intermediate and top academic ranks—25 percent were professors, 25 percent associate professors, and 38 percent assistant professors. Nearly one-third (32 percent) of the strict full-time faculty were Ph.D.'s compared to only one-tenth of the part-time faculty. From 60 to 70 percent of the total scientists and 5 percent of the clinical specialists were Ph.D.'s.

Faculty with the M.D. plus Ph.D. degree—Five percent of the faculty had earned the M.D. plus Ph.D. degree. These members were most prominently represented on the faculties of developing medical schools and schools of basic medical sciences, among professor and associate professor ranks, and in the biological sciences.

Faculty without the M.D. or Ph.D. degree—Ten percent of the faculty had not earned the M.D. or Ph.D. degree. They were most frequently reported in the lowest academic ranks and non-biological and clinical specialties such as allied health (including nursing, library science, and audiology and speech therapy), behavioral sciences, mathematics, physical sciences, and engineering.

MAJOR AREAS OF FACULTY ACTIVITY

Number of Faculty Activities by Type of Degree—Table 2.

More than eight-tenths (84 percent) of the medical school faculty performed multiple functions. In fact, the average faculty member had been assigned 2.4 major areas of activity by his medical school—2.6 for faculty with the M.D., 2.1 for Ph.D.'s, and 2.6 for faculty who had earned both degrees. While two-thirds of the M.D.'s averaged between two and three major areas of activity, 57 percent were involved in three or more activities, 30 percent in two activities, and only 13 percent reported one activity. More than five-sixths (84 percent) of the Ph.D.'s had two or more major areas of activity, and about one-sixth (16 percent) engaged in one activity. The pattern for those who had earned both degrees displayed the tendencies of both the M.D. and Ph.D. types—13 percent had one major area of activity, 35 percent had two, 35 percent had three, 16 percent had four, and one percent had five.

Faculty Activity by Type of Degree.

Faculty with the M.D. degree—Chart 1. As previously noted, the average M.D. on the medical school faculty had been assigned 2.6 major areas of activity. Practically all of them (93 percent) were teaching, approximately two-thirds (62 percent) were in research, seven-tenths (71 percent) were in service activities, 35 percent had administrative responsibilities,[1] and 3 percent performed other activities.

Faculty with the Ph.D. degree—Chart 1A. The average Ph.D. on the medical school faculty had 2.1 major areas of activity. Approximately nine-tenths (86 percent) were teaching, nine-tenths (89 percent) were in research, nearly one-fifth (18 percent) were in service activities, one-fifth (20 percent) had administrative responsibilities,[1] and one percent were in other activities.

Faculty with the M.D. plus the Ph.D. degree—Chart 1B. These faculty, like the M.D.'s, had an average of 2.6 major areas of activity. Similarly, nine-tenths (90 percent) were teaching. However, more than 85 percent were in research compared with 62 percent for M.D.'s only. Nearly one-half (45 percent) were in service activities, one-third (33 percent) had administrative responsibilities,[1] and 2 percent were in other activities.

Activity Patterns of Strict and Geographic Full-time M.D.'s and Ph.D.'s—Table 3.

The average geographic full-time faculty member had more major areas of activity than the strict full-time member. Geographic full-time faculty with the M.D. degree were assigned an average of 2.8 major activities compared to 2.7 for strict full-time members. For Ph.D.'s, the averages were 2.3 and 2.1, respectively. These differences are attributable to the fact that a larger percentage of geographic full-time M.D.'s and Ph.D.'s were involved in three of the five major areas of activity—teaching, service, and administration. These differences, barely discernible in the aggregate, become more meaningful at the sub-specialty level of detail.

Activity Patterns of Men and Women—Chart 2.

Men on the medical school faculty outnumbered women 6 to 1. They also had a higher average number of major areas of activity. The average for men was 2.5 compared to 2.1 for women. The difference in average number of major areas of activity is reflected in a higher percentage of men involved in teaching, research, and administration than women and approximately the same percentage of men and women involved in service activities. More specifically, the percentage of involvement by activity for men and women shows that: 86 percent of the men were teaching compared to 76 percent of the women, 67 percent of the men were in research compared to 49 percent of the women, 31 percent of the men were in administration compared to 21 percent of the women, and 52 percent of the men were in service activities compared to 53 percent of the women.

[1]Excludes non-faculty administrators.

Basic Specialties of Men and Women—Table 4.

Among the broad basic specialties, 88 to 91 percent of the faculty were men in the basic sciences, clinical specialties, mathematics, physical sciences, engineering, and administration. In 13 of the fine fields, men accounted for more than 90 percent of the faculty. These fields were biophysics, pharmacology, dermatology, internal medicine, medicine, nuclear medicine, neurology, obstetrics and gynecology, oncology, radiology, surgery, and administration.

There were more women in the clinical specialties and basic sciences than any other specialty group; however, they represented only 10 and 12 percent of the respective totals for these fields. The proportion of women was significantly higher in allied health and the behavioral sciences where they accounted for 55 and 36 percent, respectively. Most women classified under the allied health rubric were in nursing, library science, audiology and speech therapy, and medical illustration, while in the behavioral sciences they were in social work and psychology.

MEDICAL SCHOOL EMPLOYMENT PATTERNS

Number of Medical Schools of Employment by Type of Earned Degree—Table 5.

More than eight-tenths (82 percent) of those on the faculty during Fiscal Year 1971 had been employed by only one medical school during the preceding 10 years. Of those employed 10 or more years, 77 percent were employed by only one medical school compared to 85 percent for those employed less than 10 years. Data for faculty with the M.D. or Ph.D. degree were nearly identical to that of the total faculty. However, the mobility rate was much higher for those who had earned both degrees, and lower for those who had not earned either degree. Nineteen percent of the faculty who had earned the M.D. or Ph.D. degree had been employed by two or more medical schools compared to 25 percent for those who had not earned either degree.

Academic Rank Related to Number of Medical Schools of Employment—Table 6.

Those faculty who changed schools most often between December 1961 and the end of Fiscal Year 1971 were more likely to be in the top academic ranks than those who changed less frequently. Table 6 shows that 40 percent of the faculty who had been employed by four or more medical schools were professors in Fiscal Year 1971 compared to only 22 percent for those who remained at the same school. At the lower end of the academic ladder, only 5 percent of the faculty employed by four or more medical schools were instructors compared to 16 percent for those who remained with one medical school. This observation also applied to faculty whose total period of employment extended over a period of 10 or more years and for those whose total employment was less than 10 years.

SOURCES OF RECRUITMENT

In Fiscal Year 1971, more than seven-tenths (71 percent) of the faculty stated that they had originally entered medical school employment directly from a training program—Table 7. As expected, the sources of recruitment varied widely by faculty degree types. The data showed that two-thirds of the M.D.'s came directly from medical school or residency training, more than three-fourths of the Ph.D.'s came from medical or non-medical school training programs, and three-fourths of those with the M.D. plus Ph.D. came from medical school, residency, or non-medical school training. Twenty-three percent of the M.D.'s on the medical school faculty in Fiscal Year 1971 were employed by the same school that conferred their M.D. degree, and 41 percent were employed by the medical school responsible for their residency training. In sharp contrast, less than 4 percent of the Ph.D.'s and other non-M.D.'s on the medical school faculty were employed by the school that conferred their last degree.

Specifically, seven-tenths (71 percent) of the M.D.'s had originally entered medical school employment from a training program. This was the smallest percentage reported for any of the doctoral degree groups. Among M.D.'s recruited from training programs, 40 percent came from residency training, 27 percent from medical school training, and 4 percent from non-medical schools. The Ph.D.'s had the highest percentage (79 percent) originally entering medical school employment from a training program—43 percent from non-medical school training and 35 percent from medical school training programs. Three-fourths (75 percent) of the faculty with an M.D. plus Ph.D. degree originally entered medical school employment from a training program—34 percent from medical school training, 27 percent from a residency, and 14 percent from a non-medical school.

Approximately 30 percent of the faculty originally entered medical school employment from other employment. Among the M.D. faculty, 11 percent came from private practice, 9 percent from the Federal Government, 2 percent from State and local government, and 7 percent from other employment sources. Among the Ph.D.'s, 6 percent came from the Federal Government, 3 percent from State and local government, 1 percent from private practice, and 12 percent from other employment. Among those with the M.D. plus Ph.D. degree, 7 percent came from the Federal Government, 5 percent from private practice, 2 percent from State and local government, and 11 percent from other employment.

DISTRIBUTION OF SPECIALTIES BY DOCTORAL TYPES

Traditionally, we would expect faculty with research doctorate degrees such as the Ph.D. to be in science fields, and those with professional doctorate degrees such as the M.D. to be in clinical or other professional fields. However, these data showed that therewas a substantial crossover in medical schools—Table 8.

Nearly one-fifth (18 percent) of the doctoral faculty in the basic medical sciences were M.D.'s, 73 percent Ph.D.'s, and 9 percent had both degrees. Within the basic medical sciences, M.D.'s accounted for a substantial proportion of the

total in several fields—immunology, 34 percent; nutrition, 34 percent; genetics, 30 percent; physiology, 24 percent; general biology, 23 percent; and pharmacology, 22 percent.

In clinical specialties, 89 percent of the doctoral faculty were M.D.'s, 5 percent Ph.D.'s, and 6 percent had both degrees. Clinical fields showing a large proportion of Ph.D.'s were: nuclear medicine, 34 percent; endocrinology, 26 percent; public health and preventive medicine, 17 percent; and oncology, 10 percent.

The doctoral distribution for other disciplines showed that 95 percent of the behavioral scientists were Ph.D.'s, 4 percent M.D.'s, and more than one percent had both degrees. In the combined fields of mathematics, physical sciences, and engineering, 87 percent were Ph.D.'s, 8 percent M.D.'s, and 6 percent had both degrees. In allied health, 83 percent of the faculty were Ph.D.'s, 12 percent M.D.'s, and 5 percent had both degrees.

Administration was listed as a specialty by approximately 1 percent of the doctoral faculty—57 percent of those in administration were M.D.'s, 39 percent were Ph.D.'s, and 4 percent had both degrees.

VOLUNTEER SERVICE

Approximately one-fifth (19 percent) of the M.D.'s on the medical school faculty in Fiscal Year 1971 had served as volunteer, nonsalaried faculty in prior years. Of these members, 19 percent were men and 16 percent women. Only one-sixth (17 percent) of those with full-time appointments had served as volunteer faculty compared to more than one-third (36 percent) of those with part-time appointments. By citizenship, 20 percent of the M.D.'s who served as volunteer faculty were U.S. citizens and 13 percent were foreign.

COVERAGE

This publication is based upon data derived from the roster of full- and part-time, salaried medical school faculty maintained by the Association of American Medical Colleges (AAMC) under contract with the National Institutes of Health (NIH).

The 1970-71 faculty survey universe consisted of 103 medical schools, 87 M.D.-granting institutions, 6 schools of basic medical sciences, 8 operational developing medical schools, and 2 developing schools which were not yet operational. The response to the survey was higher in 1970-71 than in any previous year—100 percent reporting for all departments by 75 schools, fairly complete reporting by 27 schools, and only one school that did not report any data.

The data base includes 40,951 faculty—30,960 active faculty (28,099 full-time and 2,861 part-time) and 9,991 inactive faculty. This publication is based upon data from 28,452 active faculty records (25,591 full-time faculty whose records were updated in 1970-71 and 2,861 part-time faculty). Part-time faculty data were collected for the first time during 1970-71. Records for 2,508 faculty in the active file, or approximately 8 percent, were not updated. They are excluded from this publication because their true status was not known. Furthermore, the questionnaire had been revised, and their status with respect to the revisions was not known.

Table 1—Employment Characteristics of Medical School Faculty, by Sex and Citizenship: Fiscal Year 1971

Total faculty = 28,452

Employment characteristics	Personal characteristics—percentage distribution					
	Total[1]		Sex		Citizenship	
	Vertical	Horizontal	Men	Women	U.S.	Foreign
TOTAL	100	100	86	14	91	9
INSTITUTIONAL CONTROL:						
Public	51	100	86	14	92	8
Private	49	100	85	15	89	11
TYPE OF SCHOOL:						
Medical schools	96	100	86	14	91	9
Schools of basic medical science	2	100	86	14	87	13
Developing medical schools	2	100	91	9	93	7
ACADEMIC RANK:						
Professors	23	100	96	4	96	4
Associate professors	23	100	91	9	93	7
Assistant professors	34	100	84	16	88	12
Associates	3	100	68	32	84	16
Assistants	[2]	100	61	39	80	20
Instructors	14	100	69	31	85	15
Lecturers	[2]	100	63	37	96	4
No academic rank	1	100	88	12	98	2
EMPLOYMENT STATUS:						
Full-time, total	90	100	86	14	90	10
Strict full-time	62	100	85	15	89	11
Strict full-time affiliated	7	100	85	15	89	11
Geographic full-time	14	100	90	10	93	7
Geographic full-time affiliated	3	100	85	15	91	9
Full-time (type not known)	4	100	87	13	88	12
Part-time	10	100	83	17	96	4
BASIC SPECIALTY:						
Biological sciences	25	100	88	12	88	12
Clinical specialties	60	100	90	10	90	10
Math., phy.sci., and engineering	2	100	91	9	90	10
Behavioral sciences	5	100	64	36	98	2
Allied health	3	100	45	55	96	4
All other	4	100	83	17	92	8

[1]Percentages may not add to 100 due to rounding.
[2]Less than 0.5 percent.

Table 1A—Employment Characteristics of Medical School Faculty, by Type of Earned Degree: Fiscal Year 1971

Total faculty = 28,452

Employment characteristics	Type of degree—percentage distribution						
	Total[1]		M.D.	Ph.D.	M.D. plus Ph.D.	Other degree	None reported
	Vertical	Horizontal					
TOTAL	100	100	59	25	5	10	1
INSTITUTIONAL CONTROL:							
Public	51	100	56	27	5	11	1
Private	49	100	63	23	5	8	1
TYPE OF SCHOOL:							
Medical schools	96	100	60	24	5	10	1
Schools of basic medical science	2	100	38	45	7	9	-[2]
Developing medical schools	2	100	46	37	9	4	4
ACADEMIC RANK:							
Professors	23	100	62	26	10	2	-[2]
Associate professors	23	100	63	27	6	3	-[2]
Assistant professors	34	100	60	28	4	7	1
Associates	3	100	36	28	3	30	3
Assistants	-[2]	100	25	28	2	42	3
Instructors	14	100	55	13	2	28	2
Lecturers	-[2]	100	22	30	4	42	2
No academic rank	1	100	60	14	5	21	-[2]
EMPLOYMENT STATUS:							
Full-time, total	90	100	57	27	6	9	1
Strict full-time	62	100	50	32	6	11	1
Strict full-time affiliated	7	100	72	15	5	7	1
Geographic full-time	14	100	75	14	5	5	-[2]
Geographic full-time affiliated	3	100	74	14	5	6	1
Full-time (type not known)	4	100	61	21	6	9	2
Part-time	10	100	79	10	3	7	1
BASIC SPECIALTY:							
Biological sciences	25	100	17	70	9	3	-[2]
Clinical specialties	60	100	86	5	6	3	-[2]
Math., phy.sci., and engineering	2	100	5	60	4	29	2
Behavioral sciences	5	100	2	63	1	34	-[2]
Allied health	3	100	3	21	1	71	4
All other	4	100	40	24	3	28	4

[1]Percentages may not add to 100 due to rounding.
[2]Less than 0.5 percent.

Table 1B—Academic Rank of Medical School Faculty, by Type of Earned Degree: Fiscal Year 1971

Total faculty = 28,452

Academic rank	Total	Type of degree				
		M.D.	Ph.D.	M.D. plus Ph.D.	Other	None reported
	Number of faculty					
Total	28,151[1]	16,744	7,075	1,536	2,581	215
Professors	6,632	4,117	1,758	648	95	14
Associate professors	6,480	4,072	1,781	394	203	30
Assistant professors	9,576	5,769	2,668	383	696	60
Instructors	4,064	2,239	515	66	1,163	81
Associates	850	307	240	24	255	24
Assistants	117	29	33	2	50	3
Lecturers	128	28	38	5	55	2
No academic rank	304	183	42	14	64	1
	Vertical percentage					
Total	100[2]	100[2]	100[2]	100[2]	100[2]	100[2]
Professors	23	25	25	42	4	7
Associate professors	23	24	25	26	8	14
Assistant professors	34	34	38	25	27	28
Instructors	14	13	7	4	45	37
Associates	3	2	3	2	10	11
Assistants	-[3]	-[3]	-[3]	-[3]	2	1
Lecturers	-[3]	-[3]	1	-[3]	2	1
No academic rank	1	1	1	1	2	-[3]

[1] Excludes 301 faculty, or 1 percent, whose rank was not reported.
[2] Percents may not add to 100 due to rounding.
[3] Less than 0.5 percent.

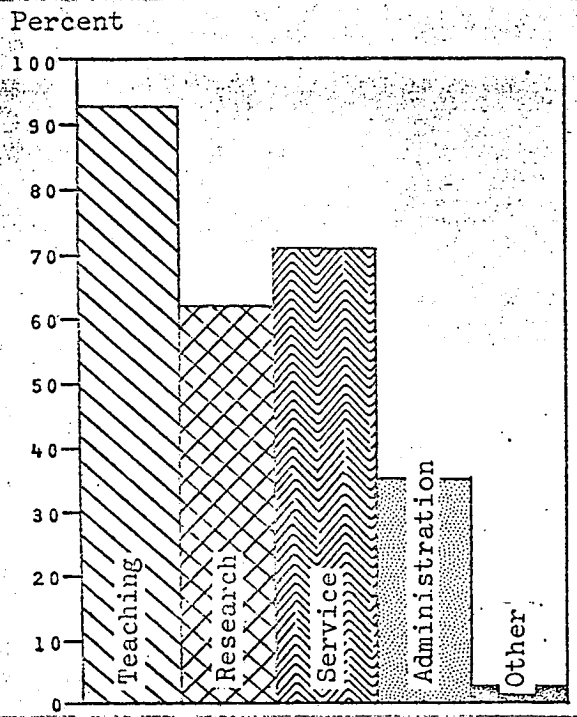
Table 2—Number of Major Areas of Medical School Faculty Activities, by Type of Earned Degree: Fiscal Year 1971

Total faculty = 28,452

Major areas of activity	Total	Type of earned degree		
		M.D.	Ph.D.	M.D. plus Ph.D.
	Number of faculty			
Total faculty[1]	27,150	16,095	6,869	1,477
Number of activities	66,136	42,411	14,690	3,787
One	4,473	2,130	1,116	192
Two	10,372	4,857	4,036	516
Three	8,466	5,988	1,390	523
Four	3,674	3,009	303	236
Five	165	117	24	10
Average number of activities	2.4	2.6	2.1	2.6
	Vertical percentage			
Total faculty	100	100	100	100
Number of activities:				
One	16	13	16	13
Two	38	30	59	35
Three	31	37	20	35
Four	14	19	4	16
Five	1	1	-[2]	1

[1]Excludes 1,302 faculty (5 percent) whose major areas of activity were not reported.
[2]Less than 0.5 percent.

Chart 1—Distribution of Major Activities of the 16,898[1] M.D.'s on the Medical School Faculty: Fiscal Year 1971

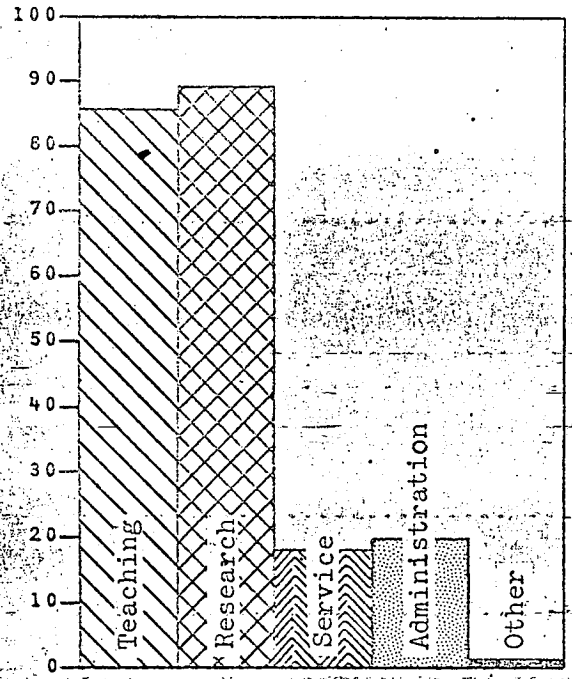


Activities	Total number	Percent of total Activities	Percent of total Faculty
Total faculty	16,095[2]		100
Total activities	42,411	100	
Teaching	14,984	35	93
Research	9,933	23	62
Service	11,432	27	71
Administration	5,636	13	35
Other	426	1	3

2.6 ← Average number activities
16,095 / 42,411
↑ Number activities
↑ Number faculty

[1]Includes 14,633 full-time and 2,265 part-time salaried faculty.
[2]Excludes 803 M.D.'s (5 percent) whose activities were not reported.

Chart 1A—Distribution of Major Activities of the 7,122[1] Ph.D.'s on the Medical School Faculty: Fiscal Year 1971

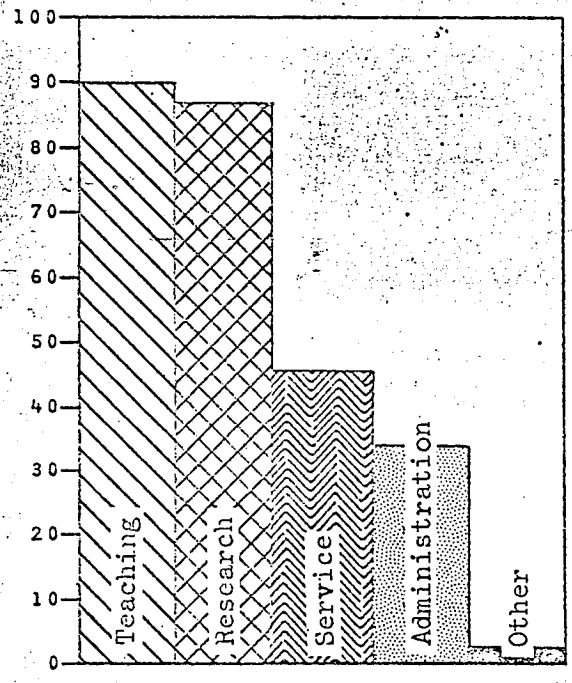


Activities	Total number	Percent of total Activities	Percent of total Faculty
Total faculty...	6,869[2]		100
Total activities	14,690	100	
Teaching.....	5,893	40	86
Research.....	6,108	42	89
Service.....	1,247	8	18
Administration	1,349	9	20
Other.....	93	1	1

2.1 ← Average number activities
6,869/14,690
↑ ↑ Number activities
Number faculty

[1] Includes 6,828 full-time and 294 part-time salaried faculty.
[2] Excludes 253 Ph.D.'s (4 percent) whose activities were not reported.

Chart 1B—Distribution of Major Activities of the 1,547[1] Medical School Faculty Who Had Earned the M.D. and Ph.D. Degree: Fiscal Year 1971



Activities	Total number	Percent of total Activities	Percent of total Faculty
Total faculty...	1,477[2]		100
Total activities	3,781	100	
Teaching.....	1,327	35	90
Research.....	1,273	34	86
Service.....	664	18	45
Administration	492	13	33
Other.....	25	1	2

2.6 ← Average number activities
1,477/3,781
↑ ↑ Number activities
Number faculty

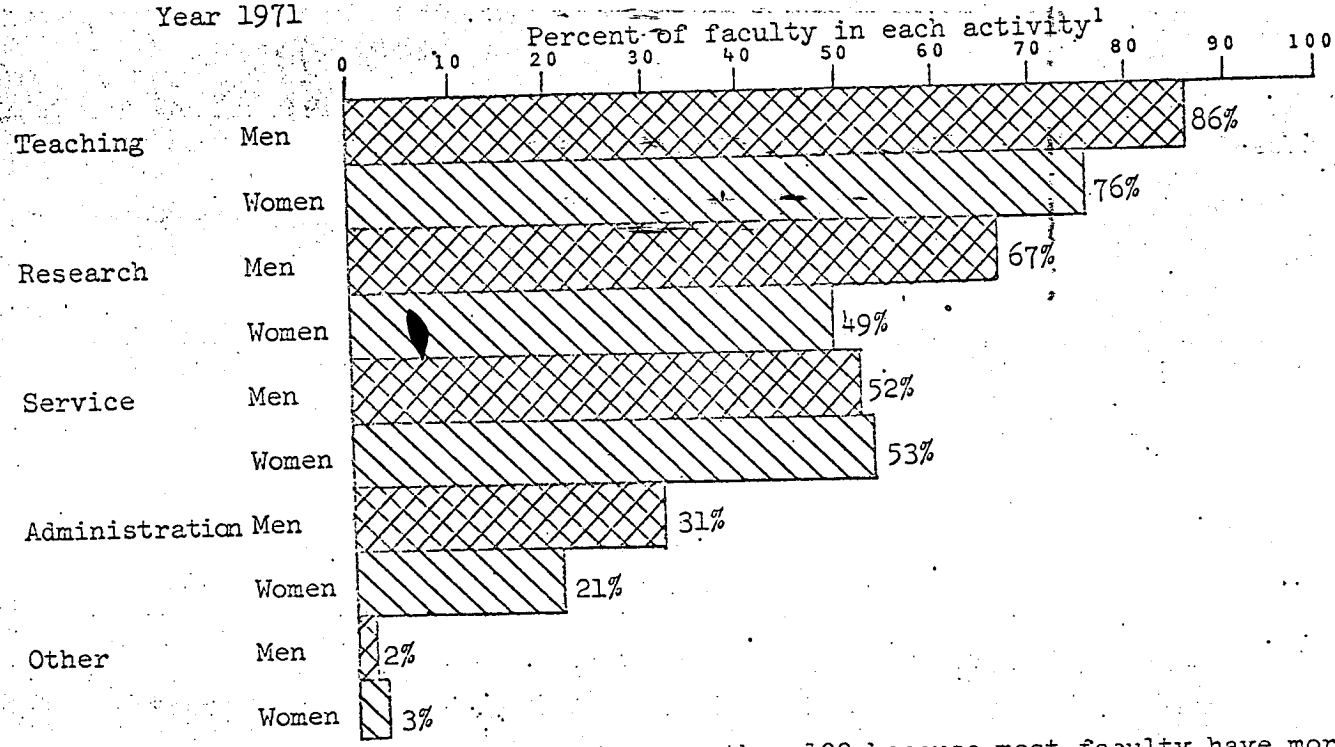
[1] Includes 1,475 full-time and 72 part-time salaried faculty.
[2] Excludes 80 M.D./Ph.D. faculty (5 percent) whose activities were not reported.

Table 3—Activity Patterns of Strict Full-time and Geographic Full-time M.D. and Ph.D. Medical School Faculty: Fiscal Year 1971

Activity	Employment status			
	Faculty with the M.D.		Faculty with the Ph.D.	
	Strict full-time	Geographic full-time	Strict full-time	Geographic full-time
Average number of activities...	2.7	2.8	2.1	2.3
Activities	100[1]	100[1]	100[1]	100[1]
Teaching	92	96	86	90
Research	68	64	91	84
Service	70	79	16	34
Administration	37	40	19	24
Other	3	3	1	1
Number of activities	100[2]	100[2]	100[2]	100[2]
One	11	9	15	15
Two	29	24	61	47
Three	39	43	19	29
Four	20	22	4	9
Five	1	1	-[3]	-[3]

[1]Subtotals exceed 100 percent because most faculty have more than one major area of activity.
[2]Subtotals may not add to 100 percent due to rounding.
[3]Less than 0.5 percent.

Chart 2—Activity Pattern of Men and Women on the Medical School Faculty: Fiscal Year 1971



[1]Percentages for men and women add to more than 100 because most faculty have more than one major area of activity.

Table 4—Basic Specialties of the Medical School Faculty, by Sex: Fiscal Year 1971

Total faculty = 28,452

Basic specialties	Number			Horizontal percentages		Vertical percentages		
	Total	Men	Women	Men	Women	Total	Men	Women
NUMBER OF FACULTY	28,218[1]	24,204	4,014	86	14	100[2]	100[2]	100[2]
NUMBER OF SPECIALTIES	37,492	32,439	5,053	87	13	-	-	-
BASIC SCIENCES	9,555	8,383	1,172	88	12	34	35	29
Anatomy	1,406	1,212	194	86	14	5	5	5
Biochemistry	2,526	2,251	275	89	11	9	9	7
Biology, general	90	72	18	80	20	-[3]	-[3]	-[3]
Biophysics	230	220	10	96	4	1	1	-[3]
Cell biology	116	101	15	87	13	-[3]	-[3]	-[3]
Zoology	57	49	8	86	14	-[3]	-[3]	-[3]
Genetics	484	393	91	81	19	2	2	2
Immunology	423	373	50	88	12	1	2	1
Microbiology	1,271	1,067	204	84	16	4	4	5
Nutrition	104	57	47	55	45	-[3]	-[3]	1
Pharmacology	1,104	1,012	92	92	8	4	4	2
Physiology	1,687	1,526	161	90	10	6	6	4
All other	57	50	7	88	12	-[3]	-[3]	-[3]
CLINICAL SPECIALTIES	22,488	20,291	2,197	90	10	80	80	55
Anesthesiology	792	666	126	84	16	3	3	3
Dermatology	238	218	20	92	8	1	1	-[3]
Endocrinology	639	575	64	90	10	2	2	2
Internal medicine	3,446	3,248	198	94	6	12	13	5
Medicine, general	2,385	2,219	166	93	7	8	9	4
Nuclear medicine	278	254	24	91	9	1	1	1
Neurology	611	574	37	94	6	2	2	1
Obstetrics and gynecology	898	831	67	93	7	3	3	2
Oncology	182	171	11	94	6	1	1	-[3]
Pathology	2,559	2,247	312	88	12	9	9	8
Pediatrics	2,263	1,699	564	75	25	8	7	14
Physical med. and rehab'n.	308	238	70	77	23	1	1	2
Public health and prev.med.	578	493	85	85	15	2	2	2
Psychiatry	2,271	2,032	239	89	11	8	8	6
Radiology	1,428	1,304	124	91	9	5	5	3
Surgery	3,465	3,391	74	98	2	12	14	2
All other	147	131	16	89	11	1	1	-[3]
MATH., PHY.SCI., AND ENG'G	849	772	77	91	9	3	3	2
BEHAVIORAL SCIENCES	1,841	1,185	656	64	36	7	5	16
Psychology	1,127	894	237	79	21	4	4	6
Social work	507	136	371	27	73	2	1	9
Other behavioral sciences	207	155	48	75	25	1	1	1
ALLIED HEALTH	1,285	584	701	45	55	5	2	17
ADMINISTRATION	363	331	32	91	9	1	1	1
OTHER SPECIALTIES	297	238	59	80	20	1	1	1
NOT KNOWN	814	655	159	80	20	3	3	4

[1]Excludes 234 faculty, or 1 percent, whose sex was not reported.
[2]Subtotals exceed 100 percent because some faculty have more than one basic specialty.
[3]Less than 0.5 percent.

Chart 3—Basic Specialties of the Medical School Faculty by Sex: Fiscal Year 1971

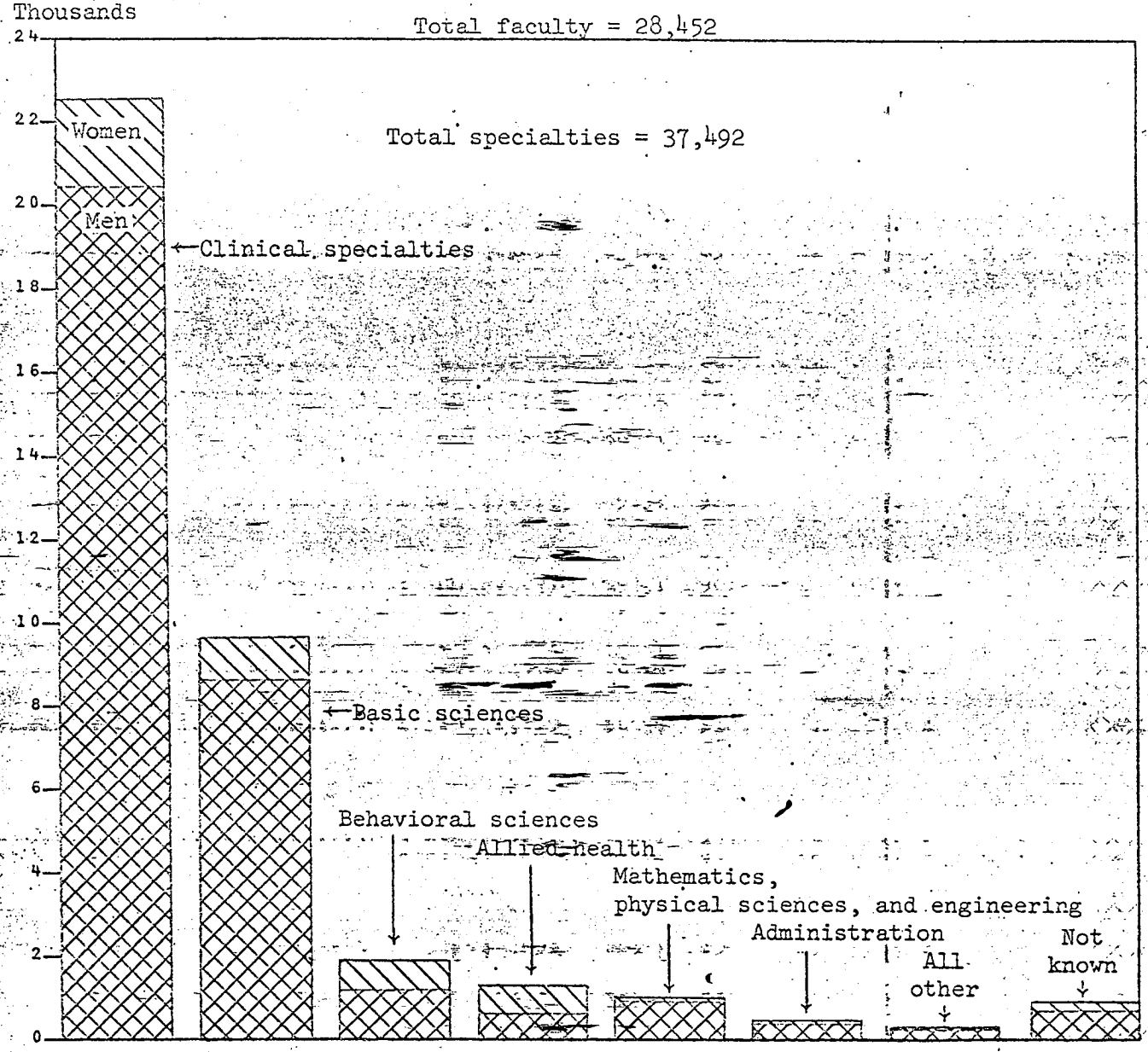


Table 5—Number of Medical Schools of Employment, by Type of Degree and Years of Employment: Fiscal Year 1971

Type of degree	Total[1]	Number of medical schools of employment in the last 10 years			
		One	Two	Three	Four or more
	All faculty				
Total	100	82	15	3	1
Faculty with the M.D. degree	100	81	15	3	1
Faculty with the Ph.D. degree	100	81	16	3	-[2]
Faculty with both degrees	100	75	20	4	1
Faculty without the M.D. or Ph.D.	100	91	8	1	-[2]
	Faculty with 10 or more years employment				
Total	100	77	18	4	1
Faculty with the M.D. degree	100	76	18	4	1
Faculty with the Ph.D. degree	100	76	19	4	1
Faculty with both degrees	100	69	24	6	1
Faculty without the M.D. or Ph.D.	100	89	10	1	-[2]
	Faculty with less than 10 years employment				
Total	100	85	13	2	-[2]
Faculty with the M.D. degree	100	84	13	3	-[2]
Faculty with the Ph.D. degree	100	85	13	2	-[2]
Faculty with both degrees	100	80	17	3	-[2]
Faculty without the M.D. or Ph.D.	100	93	6	1	-[2]

[1]Percents may not add to 100 due to rounding.
[2]Less than 0.5 percent.

Table 6—Academic Rank Pattern in Fiscal Year 1971 Relative to the Number of Medical Schools of Employment in the Last 10 Years

Number of medical schools of employment in the last 10 years	Total faculty	Academic rank Fiscal Year 1971					
		Total[1]	Professor	Associate professor	Assistant professor	Instructor	All other
	All faculty						
Four or more	149	100	40	27	26	5	2
Three	827	100	33	30	30	3	4
Two	4,223	100	28	29	33	6	4
One	23,253	100	22	22	34	16	5
	Faculty with 10 or more years employment						
Four or more	93	100	51	24	22	2	1
Three	448	100	49	29	18	1	3
Two	2,089	100	46	28	18	4	4
One	8,860	100	41	26	20	7	5
	Faculty with less than 10 years employment						
Four or more	56	100	22	31	33	9	5
Three	379	100	16	32	43	5	4
Two	2,134	100	11	30	47	8	4
One	14,393	100	10	19	43	22	5

[1]Percentages may not add to 100 due to rounding.

Table 7—Sources of Recruitment by Type of Earned Degree: Fiscal Year 1971

Medical school sources of recruitment	Total	Type of earned degree			
		M.D.	Ph.D.	M.D. plus Ph.D.	All others
Total	100	100	100	100	100
Total from training	71	71	79	75	54
Medical school	28	27[1]	35[2]	34	17
Residency	25	40[3]	1[4]	27	2[5]
Non-medical school	18	4[1]	43[2]	14	35[2]
Total from employment	29	29[1]	22[2]	25	46[2]
Federal Government	8	9	6	7	6
Private practice	8	11	1	5	4
State and local government	3	2	3	2	11
Other employment	10	7	12	11	25

[1]Twenty-three percent of the M.D.'s on the medical school faculty in Fiscal Year 1971 were employed by the same medical school that conferred their M.D. degree.
[2]Less than 4 percent of the Ph.D.'s and other non-M.D.'s on the medical school faculty in Fiscal Year 1971 were employed by a school that conferred their last degree.
[3]Forty-one percent of the M.D.'s on the medical school faculty in Fiscal Year 1971 were employed by the school that was responsible for their residency.
[4]Includes faculty who reported a Ph.D. degree and a health professional degree other than an M.D. or D.O.
[5]Includes faculty who had health professional doctors degrees other than the M.D. or D.O.

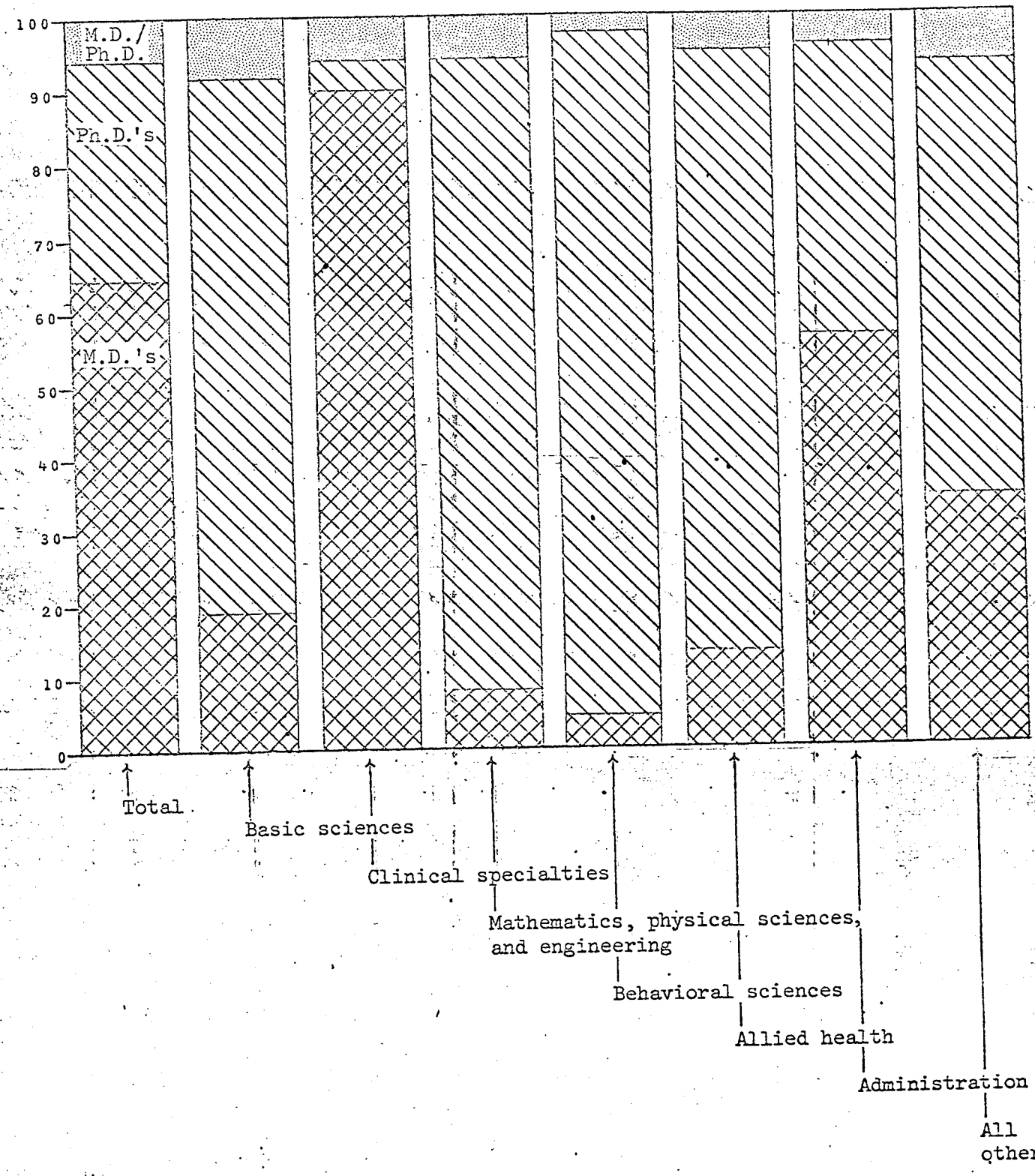
Table 8—Distribution of the Basic Specialties of the Medical School Faculty by Doctoral Degree Types: Fiscal Year 1971

Basic specialties	Total[1]	Doctoral degree types: Number of specialties			Doctoral degree types: Horizontal percentages[2]		
		M.D.	Ph.D.	M.D. plus Ph.D.	M.D.	Ph.D.	M.D. plus Ph.D.
NUMBER OF FACULTY	25,567	16,898	7,122	1,547	66	28	6
NUMBER OF SPECIALTIES	34,371	21,977	10,166	2,228	64	30	6
BASIC SCIENCES	9,189	1,629	6,738	822	18	73	9
Anatomy	1,357	184	1,045	128	14	77	9
Biochemistry	2,458	248	2,046	164	10	83	7
Biology, general	79	18	58	3	23	73	4
Biophysics	219	19	186	14	9	85	6
Cell biology	114	19	85	10	17	75	9
Zoology	52	3	49	0	6	94	0
Genetics	468	140	291	37	30	62	8
Immunology	414	139	237	38	34	57	9
Microbiology	1,179	198	910	71	17	77	6
Nutrition	74	25	35	14	34	47	19
Pharmacology	1,081	234	691	156	22	64	14
Physiology	1,639	395	1,059	185	24	65	11
All other	55	7	46	2	13	84	4
CLINICAL SPECIALTIES	22,003	19,601	1,110	1,292	89	5	6
Anesthesiology	776	735	6	35	95	1	4
Dermatology	238	213	12	13	89	5	5
Endocrinology	633	411	165	57	65	26	9
Internal medicine	3,465	3,198	75	192	92	2	6
Medicine, general	2,374	2,198	35	141	93	1	6
Nuclear medicine	359	141	88	30	54	34	12
Neurology	607	541	24	42	89	4	7
Obstetrics and gynecology	891	829	21	41	93	2	5
Oncology	180	150	18	12	83	10	7
Pathology	2,461	2,045	213	203	83	9	8
Pediatrics	2,235	2,109	37	89	94	2	4
Physical med. and rehab'n.	274	254	10	10	93	4	4
Public health and prev.med.	467	336	79	52	72	17	11
Psychiatry	2,243	2,069	102	72	92	5	3
Radiology	1,349	1,189	113	47	88	8	3
Surgery	3,419	3,104	73	242	91	2	7
All other	132	79	39	14	60	29	11
MATH., PHY. SCI., and ENG'G	596	47	516	33	8	87	6
BEHAVIORAL SCIENCES	1,230	46	1,164	20	4	95	2
Psychology	1,026	28	984	14	3	96	1
Social Work	36	3	33	0	8	92	0
Other behavioral sciences	168	15	147	6	9	87	4
ALLIED HEALTH	324	39	270	15	12	83	5
ADMINISTRATION	182	103	71	8	57	39	4
OTHER SPECIALTIES	199	67	118	14	34	59	7
NOT KNOWN	648	445	179	24	69	28	4

[1]Excludes faculty and basic specialties of those who have not earned the M.D. or Ph.D. Degree.

[2]Percentages may not add to 100 due to rounding.

Chart 4—Percentage Distribution of Doctoral Faculty Specialties Within Major Basic Specialty Categories: Fiscal Year 1971



INFORMATION ITEM 3.

OCT 23 1972

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

TO: TASK FORCE ON COST OF GRADUATE MEDICAL EDUCATION & FACULTY PRACTICE PLANS

FROM: Robert H. Kalinowski, M.D. and Richard M. Knapp, Ph.D.

SUBJECT: Minutes of September 19, 1972 meeting

Present:

Dr. William Anlyan
Dr. Christopher Fordham
Dr. Arnold Relman
Mr. Charles Womer

Guest:

Mr. Ronald Lochbaum

AAMC Staff:

Dr. John Cooper
Dr. Robert Ball
Miss Grace Beirne
Mr. Thomas Campbell
Mr. Charles Fentress
Dr. Robert Kalinowski
Dr. Richard Knapp
Mr. Joseph Rosenthal
Dr. Marjorie Wilson

Following approval of the Minutes of the July 19th meeting, Dr. Anlyan requested that Dr. Cooper report on the September 13th meeting of the parent committee. Dr. Cooper stated the purpose of that meeting was to:

1) Obtain the Committee's views of the direction and content of its report to the Assembly, focussing upon a first draft statement of this report, prepared by Mr. Murtaugh (this draft was sent to Committee members on September 8, 1972), and

2) Review the progress of the Task Force on Cost of Medical Education in its detailed study of the cost of undergraduate medical instruction at eight medical schools.

Committee Report

The Committee had made the decision (at earlier meetings) to focus its attention on the problems arising from Federal policy to provide financial support to medical schools on the basis of the enrollment of undergraduate medical students and increases in that enrollment, and the coupled Congressional directive to the Secretary, DHEW to launch a study to establish the methodology for ascertaining the "annual per student educational cost" of the program leading to the M.D. degree, to determine such costs for the 1971-72, 1972-73, and 1973-74 (estimated) school years; to describe national uniform standards for each medical school to use in determining these costs, and to recommend how these cost determinations could be used in fixing the payments to the school through capitation grants.

Congress called for an interim report on March 30, 1973, and a final report by January 1, 1974. The National Academy of Sciences - Institute of Medicine is conducting this study. (Comprehensive Health Manpower Training Act of 1971).

Because of the urgent need for the Association to make known its views on these critical matters, the Committee decided, as shown in the minutes of the July 12th meeting, to provide a report to the Assembly at the November annual meeting which would:

> "establish the view of the Association concerning (1) the complexity of the medical education process -- the interrelatedness of the elements that are integral to that process (instruction, research, services);(2) the indivisibility of that process, beginning with the curriculum leading to the M.D. degree through the years of internship and residency; (3) that only upon the completion of this continuum can the national objective to increase the number of persons capable of performing the functions of physicians in the delivery of health care be satisfied.
>
> The report will therefore stress the essentially arbitrary nature of efforts to establish estimates of the costs of undergraduate medical education, since this is a discrete concept only in the sense that a degree is awarded upon its completion and not in terms of the preparation of an individual for the independent practice of medicine.
>
> However, because of pressures for such estimates, the Association will present a set of preliminary figures, for consideration as a guide to the probable costs of this segment of the continuum - to be followed by more definitive views of the entire medical education process, its costs, and financing, in the context of the broad range of activities of the contemporary medical center complex."

Following the prescriptions outlined in the July 12th directive, Mr. Murtaugh prepared the draft statement, reviewed by the Committee at this meeting. This first draft, however, did not include preliminary findings of the Committee's Task Force groups on the costs of undergraduate medical education process. It is now evident that because of the inherent difficulties in establishing cost estimates for the research and patient care components, and because the group studying the patient care aspect has only recently been organized, cost estimates will not be available in time for the report to the Assembly in November.

In view of this, and as a result of the day's discussion, the Committee decided to:

(1) Provide the Assembly in November with an interim progress report of the Committee's work, leading to

(2) A full report - a more definitive statement of the Association's views - following the July 12th directive, and including preliminary estimates of the costs of undergraduate medical education - to be released, after Executive Council/Assembly review, early in the spring of 1973. The timing of the release of this report is crucial, in view of the convening of the new Congress, which will be concerned with the extension of the Comprehensive Health Manpower Training Act of 1971, and the scheduled release of the interim report by the Institute of Medicine.

From the standpoint of a time frame for Task Force activity, Dr. Anlyan suggested that the group move forward with overall Committee on the undergraduate effort and then "review the bidding".

At this point, the Task Force discussed the components of the hospital budget which could be specifically ascribed to undergraduate medical education. These are as follows:

- house staff costs which can be allocated to the function of instructing undergraduate medical students (this would also include teaching physicians who are paid on the hospital budget);

- the cost of nursing, technician or other staff time as well as the allocation of other hospital cost centers (such as medical records, nursing service or social service) devoted to undergraduate medical education;

- the cost for hospital space allocated to undergraduate students.

Each of these three components of the hospital budget are included in the medical center cost studies. Mr. Campbell reported that the special eight center study was under way, but specific data on these allocations are not yet available.* Mr. Campbell further elaborated on the methodology used to allocate educational program costs to these three components.

Preliminary data available on the eight center study do indicate that while there are dollars in the hospital budget devoted to undergraduate education; the amount is relatively small when calculated as a percentage of the hospital budget. Following a lengthly discussion, the Task Force agreed on the following general statement.

> Given the general attributes of a teaching hospital in terms of the presence of graduate medical educational programs, the character of its patient population, the scope of service provided, and the staffing levels implicit in the discharge of such

*the eight centers involved are as follows:
a) Duke U. Sch. of Med. - Case Western Reserve U. Sch. of Med.
b) Georgetown U. Sch. of Med. - St. Louis U. Sch. of Med.
c) U. of Kansas Sch. of Med.-S.U.N.Y., Upstate Med. Ctr.
d) U. of Iowa Sch. of Med. - Ohio State U. Sch. of Med.

activities, the conduct of an undergraduate medical educational program in such a setting has only a minor effect (probably not exceeding 1%) on the overall patient care costs of such institutions. The Task Force will review cost study data when it becomes available to determine if there is a need to reconsider its position.

A further matter of concern is the problem of estimating the effect of teaching undergraduate medical students on such items as length of stay of patients, utilization of laboratory and x-ray services, as well as other measures of patient care and hospital service. After full discussion of the matter, the Task Force did not come to full agreement. The following statement characterizes the feeling of the group:

The current evidence available concerning the additional effect of the presence of medical students on laboratory, x-ray and other service utilization cannot be considered either sufficient or conclusive. Further, if any part of the costs of such increased services are considered educational in nature, they would in large part be attributed to graduate rather than undergraduate medical education.

At this point in the meeting Dr. Anlyan led a general discussion of the costs of graduate medical education and the need for more data and information concerning medical faculty practice plans. The staff was directed to examine the patient care components in the eight center study with specific reference to the cost of graduate medical education and to set forth a plan to:

1) examine institutional policies concerning faculty practice plans;

2) collect these plans from each of the schools;

3) determine the cash flow generated by these practice plans.

The next meeting of the Task Force is to be held on a date yet to be determined in early December.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

MINUTES

RMP-CHP COMMITTEE
September 6-7, 1972
Embassy Row Hotel - AAMC Conference Room
Washington, D.C.

Present

Stuart M. Sessoms, M.D., Chairman
Alexander M. Schmidt, M.D.
James V. Warren, M.D.
William R. Willard, M.D.

Absent

Andrew D. Hunt, Jr., M.D.
William S. Jordan, M.D.
William H. Stewart, M.D.

AAMC Staff

Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Joseph S. Murtaugh
Stephen J. Ackerman
Grace Beirne
Prentice Bowsher
Rosemary Wilson
Alexa Burt

RMP-CHP Committee Minutes

I. Meeting with HSMHA Officials, September 6

The RMP-CHP Committee held an informal meeting with Dr. Vernon Wilson and key members of his staff at the Embassy Row Hotel on the evening of September 6, 1972. Dr. Wilson, who was accompanied by his deputy, Mr. Gerald Riso; Mr. Robert Janes, chief of CHP programs; and Dr. Harold Marguiles, chief or RMP; led a discussion on the evolution and background of HSMHA-HEW policy on the issue. This was followed by a period of full and free discussion involving the entire group. Key points in the HSMHA policy as articulated by Dr. Wilson were:

A. The concept of an "implementing agency" designed to serve as an approval authority for the expenditure of all federal funds (and possibly funds from state and other sources) for health care programs within the state.

B. The principle that "planning" and "action" functions must be kept separate and lodged in completely separate agencies.

II. Committee Discussion, September 7

All members of the committee participated in a group discussion on the perceptions and insights derived from the discussions with Dr. Wilson and his staff and then went on to a general discussion with regard to the subject of the RMP-CHP issue generally and the committee's approach in carrying out its function. Among the concepts and formulations contributed by various individuals during the course of the discussion were the following:

A. General Policy Issues: Federal-State Relationships

1. Fundamental policies of the Nixon Administration which have a determining influence on the programs involved include:
   a. Decentralization
   b. Revenue sharing

2. It is a sound approach to build on the strengths that we already have in this area.

3. In this regard, legislative authorizations could put emphasis on the end rather than the means (the end being the availability and accessibility to the means of quality health care for all through overall planning and regulation and/or control of the health care system) and authorize means (program mechanisms) to be oriented to the end purpose.

4. In line with Dr. Wilson's statement, the states should be given a good deal of flexibility and responsibility for self-determination in re the means or agencies used to achieve the end.

B. Planning Decision Making and Action Process in Re the Health Care System

1. The policy that mandates the separation of planning and action is viewed as an obsolete concept by some political scientists.

2. A more current concept of planning was described as a process of bringing together the forces having the power to create change in a given situation.

3. A case in point was cited involving an academic medical center which found it necessary to obtain 32 different approvals before the construction of a new hospital could be undertaken. The point made was under such circumstances, if there was to be a viable health care plan that the 32 "real-power" interests would have to be involved in its development.

4. Unless CHP has the real power wielders and money controllers built into its structure, it cannot do the job.

5. The so-called implementing agency should have a positive role with regard to the health care system as well as the negative one of refusing fund approval.

6. Planning, decision making, and implementation are actually different essential steps in one continuous process. It can, therefore, be effectively accomplished either within one agency or through interrelated agencies. Policy and process should determine the structure--not vice versa.

C. Implications for Academic Medical Centers

1. The control or dominance of medical schools in RMP is waning but activity and involvement is increasing. Examples: regionalization of health care on a capitation basis and manpower planning and development.

2. There is ambivalence of viewpoint in re the medical school relationship here. Some say this is where the talent is, but others question the extent or appropriateness of the talent. There is also an anti-medical school attitude prevalent in some quarters.

3. The focus should be on the university rather than the medical school.

4. Academic medical centers have a vital stake and interest in the community related health care functions that demand rationalization and coordination of approach.

D. Some Prime Issues Needing Resolution

1. Need for clear articulation of the mission and objectives for the programs involved

2. Clarification of the distinction of the implementing agency and the planning agency

3. A construct of the planning agency or process

4. Determination of how can the CHP process be strengthened? Or if a new reconstituted process is necessary.

5. Where does the Experimental Health Service Delivery System program fit in? (lack of satisfaction with the HSMHA explanation on this point)

6. Identification and definition of the devices and framework that can meet the needs

7. Assessment of the implications to the extent that these things involve the academic health center?

III. Report on Site Reviews on RMP-CHP Interrelationships

A. Arkansas, Connecticut and Vermont

Dr. Kalinowski and Mr. Ackerman gave a report on their visits with key officials from the above three states. A written staff report was distributed. The highlights derived include:

1. RMP as a general rule is rich in talent and money; CHP is poor.

2. RMP's power, however, is short-circuited by the lack of a clear mandate, purpose, and public responsibility.

3. In summary: RMP has a capability but not a mandate; CHP has a mandate but not capability; present HEW policy prevents them from putting it together.

4. The Experimental Health Services Delivery System Program is a part of the problem rather than a part of the solution.

5. RMP has developed a strong constituency--partly political because it puts money in every Congressional jurisdiction and partly professional because practicing physicians trust it as a program that serves their interest and is not inimical to it.

6. Few would vote for continuation as is.

7. All three programs gave evidence of the fact that nothing substantial could be accomplished in the rationalization of the health care system without finding some way of providing for the substantial participation of the practicing physicians group.

8. A major problem in the existing situation has been the paradox of an unduly weak federal tendency to articulate the specific national purpose and relationships of the programs concerned on the one hand, and an unduly strong tendency to direct states and communities in the nature and details of implementing action.

B. Louisiana

Dr. William Stewart could not attend the meeting because he was out of the country. In lieu of a report on the Louisiana situation, a letter which he had sent to Dr. Kalinowski was distributed. Its essence is as follows:

"After reviewing the minutes of the last meeting, I am convinced that it is vital to develop new objectives for a combined CHP-RMP program before a discussion of the wisdom of the combination can be undertaken. It could be that the original objectives of CHP and RMP are still valid or that they are no longer valid for a variety of reasons. The real problem could be that no clear purpose expressed as current operational public policy exists. No organizational changes or name changes of these programs is going to solve this problem."

C. Illinois

Dr. Max Schmidt gave a report on his review of the situation in Illinois. Major points in the report included:

1. There are good close relationships among key people in the state and some good program activities along with a good deal of specific problems.

2. The RMP has a number of substantive program activities; medical school domination is lessening but RMP-type activities are growing.

3. The governor has appointed Dr. Snoke as coordinator of health care, but he has little resources to work with and his function parallels that of the state health agency with a resulting atmosphere of competitive sensitivity.

4. A general agreement exists that CHP should have the supraordinate role, but CHP has produced no substantial plan or program.

5. RMP feels that in absence of a plan, the CHP review represents another technical project review on top of the one already made by the RMP advisory group, rather than one of a conceptual or strategic nature.

6. Despite their problems, there are active, cooperative projects, a good example being the "interagency task force for health manpower" in which CHP, RMP, the Medical Society, Hospital Council and State Board of Health have joint involvement.

IV. Synthesis of Essential Concepts and Basic Forces

It was suggested that it might be productive for the committee to attempt to define the essential concepts and fundamental forces pertaining to the RMP-CHP problem without regard to the specific agency structure or specific prescription of solution at this point. On the basis of total group discussion, the following outline of such prime factors was evolved.

A. Major forces

1. Comprehensive health planning on a geographic basis

2. Revenue sharing

3. Decentralization of decision making

4. Enlargement of public base in decision making

5. Super agency as conduits of funds (veto power)

   a. Regional office
   b. Implementive agency
   c. CHP (A)

B. Planning process

1. Quality of people

   a. Funding
   b. Power and authority

2. Subject and content of planning

   a. Health vs. medical care delivery
   b. Manpower development and distribution
   c. Resource investment
   d. Quality
   e. Evaluation

3. Geographic Area

4. Public acceptance and accountability

5. Object of plan to be controlling

6. Relationships to action process

C. Action process

1. Relationship to planning

2. Resource allocation

   a. Facilities
   b. Manpower
   c. Money

3. Assignment of authority and responsibility

4. Feedback mechanism

V. Committee Position Paper

It was agreed that the AAMC staff should develop a position paper based on the above outline and with reference to the similar outline with regard to the problems of the health care system derived from the first meeting. The draft position paper would be submitted to the committee for review prior to the next meeting and when finalized would be transmitted for the views and comments of the AAMC constituency through appropriate channels.

COTH ADMINISTRATIVE BOARD MEETING
PDR 5
Palmer House
Chicago, Illinois
August 6, 1972

PRESENT:

George E. Cartmill, Chairman
Leonard W. Cronkhite, Jr., M.D., Chairman-Elect
Irvin G. Wilmot, Immediate Past Chairman
Robert A. Derzon
Joe S. Greathouse, Jr.
Arthur J. Klippen, M.D.
Sidney Lewine
Russell A. Nelson, M.D.
Roy S. Rambeck
Stuart M. Sessoms, M.D.
David D. Thompson, M.D.
Thomas H. Ainsworth, Jr., M.D., AHA Representatove

STAFF:

John A. D. Cooper, M.D.
Grace W. Beirne
Robert H. Kalinowski, M. D.
Richard M. Knapp, Ph.D.
Catharine A. Rivera

I. Call to Order:

Mr. Cartmill called the meeting to order at 9:00 a.m. in Private Dining Room 5 of the Palmer House.

III. Consideration of Minutes:

The minutes of the meeting of May 18, 1972 were approved as distributed.

III. Report of the COTH Ad Hoc Membership Committee:

Mr. Wilmot reported on the meeting of the COTH Ad Hoc Membership Committee held in New York City on June 16, 1972. It was recommended that paragraph 3 on

on page 3 of the Report be changed to read as follows:

> "The Committee holds that membership in the Council of Teaching Hospitals of the AAMC should be determined and interpreted solely for the purpose of advancing the objectives of COTH and its constituent members. The current request for classification of hospitals within COTH arises from the new practice by various agencies of classifying teaching hospitals for reimbursement purposes. The Committee believes that it is an error to use membership, or a category of membership in COTH, for such purposes. It is therefore recommending that no attempt be made to do so in the future until and unless such an effort serves the purpose of advancing the objectives of the Council of Teaching Hospitals and its constituent members."

Two specific recommendations are contained in the Report. Appendix A, entitled "Differential Characteristics of Teaching Hospitals," was approved as presented. A discussion then ensued concerning Appendix B which recommended changes in the current criteria for membership in COTH. Following discussion, there was general agreement that since the distinction between undergraduate and graduate education is becoming increasingly "blurred," reference in the criteria for medical school affiliation should be made to medical education generally, rather than specifying undergraduate or graduate education.

Specific changes in Appendix B are as follows:

Page 1, number (1) Under Eligibility
Strike "undergraduate"

Page 2, Paragraph 1, Sentence 2
After "children's" insert "and such other specialty"

Strike "graduate" and "undergraduate"

Page 2, Paragraph 2
Strike "graduate"

The Report as modified appears as Appendix A to these minutes.

ACTION #1 IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH AD HOC MEMBERSHIP REPORT, AND THE RECOMMENDATIONS CONTAINED THEREIN, BE APPROVED AS MODIFIED. THE ADMINISTRATIVE BOARD RECOMMENDS THIS REPORT BE FORWARDED TO THE COTH INSTITUTIONAL MEMBERSHIP, AAMC EXECUTIVE COUNCIL AND AAMC ASSEMBLY TO BE ADOPTED AS AAMC POLICY.

IV. Current Status Of The AAMC Committee On Financing Medical Education:

Dr. Cooper reported on the current status of the AAMC Committee on Financing Medical Education. He stated that there was increasing concern about continuing the present approach - that is, to present as a separate set of numbers identified as the real cost of undergraduate medical education. Essentially, the magnitude of dollars and effort devoted to undergraduate medical education is not large enough to encompass or account for the size of the financial problems being experienced. In other words, this group of institutions is not in financial difficulty due solely to the undergraduate medical education process. Thus, the Report in October will view the matter in a much larger context.

Specifically, it was agreed at a recent meeting on July 11 that:

The Committee's report to the Assembly will seek to establish the view of the Association concerning (1) the complexity of the medical education process -- the interrelatedness of the elements that are integral to that process (instruction, research, service); (2) the indivisibility of that process, beginning with the curriculum leading to the M.D. degree through the years of internship and residency; (3) that only upon the completion of this continuum can the national objectives to increase the number of persons capable of performing the functions of physicians in the delivery of health care be satisfied.

The report will therefore stress the essentially arbitrary nature of efforts to establish estimates of the cost of undergraduate medical education, since this is a discrete concept only in the sense that a degree is awarded upon its completion and not in terms of the preparation of an individual for the independent practice of medicine.

However, because of pressures for such estimates, the Association will present a set of preliminary figures, for consideration as a guide to the

probable costs of this segment of the continuum - to be followed by more definitive views of the entire medical education process, its costs, and financing, in the context of the broad range of activities of the contemporary medical center complex.

Dr. Cooper stated that the question which most likely is of greatest concern to COTH is the patient care cost component of medical education. Dr. Anlyan is Chairman of a Task Force which is reviewing this question. Chuck Womer from Yale is the COTH representative on this Task Force. A staff paper prepared for use by the Task Force entitled, "Medical Education -- The Patient Care Cost Component," is attached as Appendix B to these minutes.

An intensive discussion took place concerning the staff paper, with the following points being made:

- when students participate in the patient care process, productivity is frequently decreased with a subsequent decrease in revenue which is difficult to state in cost accounting terms;
- the third component in the staff paper should definitely be excluded; if the cost allocation methodology is pursued, it should be done on an incremental rather than a joint cost basis;
- it may not be wise or possible to prospectively set forth specific program costs, since the diversity of arrangements and scope of programs in the medical centers could be threatened by a single cost accounting approach to the problem;

- the matter of public statements concerning educational costs must be carefully reviewed, since the third party payors will use to advantage any statement which implies that patient care dollars are being used to support certain educational programs.

Dr. Cooper suggested that the sense of the Administrative Board's discussion be communicated to Dr. Anlyan's Task Force, and that the COTH officers serve as ex officio members to that Task Force as well as the overall Financing Committee.

V. "Resolution On The Representation Of Basic And Clinical Scientists In Academic Health Centers"

This item was initiated by the Council of Academic Societies, and referred for action by the AAMC Executive Council. The statement was reviewed and briefly discussed.

ACTION #2 IT WAS MOVED, SECONDED AND CARRIED THAT THE ADMINISTRATIVE BOARD OF THE COUNCIL OF TEACHING HOSPITALS ENTHUSIASTICALLY SUPPORT THE "RESOLUTION ON THE REPRESENTATION OF BASIC AND CLINICAL SCIENTISTS IN ACADEMIC HEALTH CENTERS." 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

ACTION #2 ... 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.

VI. Health Services Advisory Committee Activities:

Dr. Kalinowski reported that the Advisory Committee met on May 31, 1972. A final report on the HMO contract has been submitted to HSMHA. An editorial board has been established to review presentations at the eight regional workshops for publication, possibly as a supplement to the Journal of Medical Education. A new eighteen month contract has been signed, the purpose of which is to plan and carry out activities directed toward the development of at least five HMO's in university medical centers.

Three general areas were recommended by the Advisory Committee as programs which should be initiated during the coming year:

(1) projects directed toward upgrading the performance of hospital out-patient departments;

(2) activities related to primary care education programs, particularly as they might be developed in HMO's;

(3) efforts which would serve to bring about more analytical attention to the problems of measuring the quality of health services.

Dr. Kalinowski stated that the staff is visiting a number of institutions which are making concerted efforts to improve the quality of care provided in outpatient departments. Concerning primary care, discussions have been held with the Bureau of Health Manpower in an attempt to generate interest in primary care educational programs and the possibility of funding some projects in concert with HMO's and other primary care efforts.

A subcommittee of the Health Services Advisory Committee has been appointed to study quality of care issues and methodologies, and is scheduled to meet on September 28-29. Members of the subcommittee are as follows:

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

David R. Challoner, M.D.
Vice Chairman of Medicine
Indiana University Medical Center

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

Richard L. Meiling, M.D.
Vice President for Medical Affairs
The Ohio State University
College of Medicine

John H. Westerman
Director
University of Minnesota Hospitals

VII. Report of the RMP/CHP Committee:

Dr. Sessoms, Chairman of the Committee, reported that the group had its first meeting on June 15. Other members of the committee are:

Andrew D. Hunt, Jr., M.D.
Dean
College of Human Medicine
Michigan State University

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

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

William R. Willard, M.D.
Dean
College of Community Health Sciences
The University of Alabama

Dr. Sessoms pointed out that the RMP and CHP legislative authority will expire on June 30, 1973. Consequently, it is important that the AAMC be prepared to state its position when the time arises. Three general questions are being pursued:

- how do RMP and CHP presently function, and how are these programs affecting the AAMC constituency?
- in what fashion do we think RMP and CHP should perform, and how should they relate to the AAMC constituency?

- what action, legislative or administrative, is necessary to achieve these goals?

The staff is visiting situations where it is reported that RMP and CHP are integrating objectives and staff to achieve a common goal. In addition, various regional and national administrators of these programs are being contacted for their views on the question. The next meeting is scheduled for September 6-7, 1972, when Dr. Wilson, Administrator of HSMHA, Dr. Margulies, RMP Chief, Mr. Janes, CHP Chief and Deputy Administrator Gerald Riso will be present to discuss the two programs with the Committee.

VIII. Current Status of NIRMP:

Dr. Cooper reported that with the current confusion regarding the status of the internship, as well as other matters, NIRMP is experiencing some difficulties in maintaining its function. Additionally, some specialty groups are not fully cooperating with the plan. He stated that various procedural alternatives for improving the effectiveness of the plan were being discussed and he asked for suggestions.

One specific suggestion offered was that no hospital be allowed to accept a student that has already signed with another hospital under penalty that the latter hospital be dropped from participation in NIRMP. The Board members stated that they would work in their own hospitals toward discouraging abuse of the system.

IX. Information Items:

Dr. Knapp reported briefly on the following information items:

A. COTH Annual Meeting Program

B. Special Annual Meeting Session with the Veterans Administration

C. Memorandum Concerning St. Joseph Infirmary

D. Proposed Statement on a Patient's Bill of Rights

E. Resignation of Don Arnwine

F. Discontinuation of the February Meeting of the AAMC Assembly

G. Hospital Administrators who have participated in an LCME Medical School Accreditation Visit

H. Renewal of Hill Burton legislation

Concerning the Hill-Burton legislation two points were made by several members of the Board:

- the emphasis on the need for new and modernized ambulatory facilities should not be taken to the point where inpatient needs are completely excluded;
- the reference to facilities which provide the environment for manpower development should be strongly emphasized.

With the discontinuance of the February meeting of the AAMC Assembly, it was pointed out that the Council of Deans and Council of Academic Societies are planning spring sessions. There was a brief discussion of the question of whether COTH should follow suit. Tentative agreement of the Board was that no new meeting should be planned. However fuller discussion of the matter should take place at the November 2 meeting of the Board.

X. Adjournment:

There being no further new business, the meeting was adjourned at 2:30 p.m. The next meeting of the Board will be held on Thursday, November 2 in the Champagne Room of the Fontainbleau Hotel from 3:00 p.m. to 5:30 p.m.

APPENDIX A

COTH AD HOC MEMBERSHIP COMMITTEE REPORT

The first meeting of the Committee was held on June 16 in New York City. The Chairman, Irvin Wilmot, presided and all members were present. The charge to the Committee as set forth by the Administrative Board is as follows:

> It was moved, seconded and carried that a moratorium be declared on new applications for COTH membership. The Chairman was directed to activate a committee with the following charge:
>
> (A) To examine the institutional characteristics of the present COTH membership.
>
> (B) To examine the current criteria for membership, and make recommendations for desirable changes for the future.
>
> (C) To examine the selection process including the possibility of moving toward some form of institutional evaluation and review.

A wide variety of background material was reviewed by the Committee including the three task force reports presented at the 1971 COTH Annual Meeting. Additionally, the institutional characteristics of the present membership were examined in depth. At the time of the analysis, there were 404 COTH members, 41 of which had no reported affiliation with a school of medicine. Sponsorship of the residency programs ranged from less than five to more than twenty. Other statistical indices reviewed included size, institutional expenditures, and the scope of services provided.

The Committee is well aware that there have been suggestions from various quarters that the COTH membership be grouped or classified on the basis of some uniform criteria. In this context it is worthwhile to recall the presentation made last year by Stanley Ferguson, Chairman of the Task Force to

Analyze the Higher Costs of Teaching Hosptials. His Task Force identified the following diemnsions which characterize the unique nature of the teaching hospital:

(1) the size and scope of the intern and resident staff;

(2) the number of fellowship positions;

(3) the extent to which the full range of clerkships is offered to undergraduate medical students;

(4) the number and scope of allied health education programs sponsored by the hospital, or in which the hospital participates;

(5) the volume of research undertaken;

(6) the extent to which the medical faculty is integrated with the hospital medical staff in terms of faculty appointments;

(7) the nature and substance of the medical school affiliation arrangement;

(8) the appointment of full-time salaried chiefs of service;

(9) the number of other full-time salaried physicians;

(10) the number of special service programs offered, e.g., neonatal care units, pediatric evaluation centers or renal dialysis units;

(11) the level of complexity demonstrated by the diagnostic mix of patients;

(12) the staffing pattern and ratios resulting from the distinctive patient mix;

(13) the scope and intensity of laboratory and X-ray services;

(14) the financial arrangements and volume of service rendered in outpatient clinics.

Individual hospitals meet each of these characteristics in varying degrees. Ideally, the objective would be to examine the extent to which each hospital meets each chosen criteria, and classify accordingly.

Some of these dimensions are already in use in various parts of the country as the basis for grouping hospitals for reimbursement purposes. However, the choice of variables differs, as it should, according to local or state needs and conditions.

The Committee holds that membership in the Council of Teaching Hospitals of the AAMC should be determined and interpreted solely for the purpose of advancing the objectives of COTH and its constituent members. The current request for classification of hospitals within COTH arises from the new practice by various agencies of classifying teaching hospitals for reimbursement purposes. The Committee believes that it is an error to use membership, purposes or a category of membership in COTH, for such purposes. It is therefore recommending that no attempt be made to do so in the future until and unless such an effort serves the purpose of advancing the objectives of the Council of Teaching Hospitals and its constituent members.

However, in this regard, the Committee does have two recommendations. The first appears as Appendix A to this report, and is concerned directly with the issue under discussion. The Committee recommends that this statement entitled, "DIFFERENTIAL CHARACTERISTICS OF TEACHING HOSPITALS," be approved by the COTH institutional members and forwarded through appropriate channels to be adopted as AAMC policy.

The second recommendation of the Committee is in response to our charge to examine the current criteria for membership, and appears as Appendix B to this report. In setting forth these criteria, the Committee kept in mind the fact that the AAMC, of which COTH is an integral component, is devoted to

the advancement of medical education. Therefore, the Committee believes that the criteria for COTH membership should continue to be based on the hospital's commitment to undergraduate and graduate medical education.

It is anticipated that a number of teaching hospitals which are presently COTH members may not meet the newly proposed membership criteria. It is the Ad Hoc Committee's recommendation that these hospitals continue to be active members of the Council. In three years time the criteria should again be reviewed, and at that time the ability of all present members to meet these criteria should be assessed.

In response to our final charge, the Committee does not find it appropriate to recommend that the selection process for new COTH members be changed. Institutional visitations for the purpose of evaluating prospective COTH members would be a time consuming and expensive process. Additionally, the recent establishment of the Liaison Committee on Graduate Medical Education as well as other developments in graduate medical education make the present an inopportune time to establish another process of hospital review and evaluation.

IRVIN G. WILMOT, Chairman

Arthur J. Klippen, M.D.
Sidney Lewine
Charles B. Womer

DIFFERENTIAL CHARACTERISTICS OF TEACHING HOSPTIALS

The criteria set forth to obtain membership in the Council of Teaching Hospitals were established to provide a basis from which hospitals could organize and promote the hospital as an educational institution. Hospitals differ greatly in the scope, breadth and depth of their commitment to educational purposes, the characteristics of patients they serve, and the nature and scope of services they provide. Consequently, membership in COTH of AAMC cannot be assumed to represent program or operating equivalence, or even similarity, to any significant degree.

At least three major factors must be considered when attempting to characterize or classify hospitals:

-- The nature and scope of the hospital's educational objectives and the degree of institutional commitment to meet the incremental costs of providing the environment for undergraduate and graduate medical education, and allied health education;
-- The severity of illness, complexity of diagnosis, and socio-economic characteristics of the patients served by the hospital;
-- The comprehensiveness and intensiveness of services provided by the hospital.

There is a great variation in the extent to which each teaching hospital meets these dimensions. Any attempt to characterize or classify teaching hospitals must recognize the limitations of grouping all teaching hospitals based upon their membership in COTH.

CRITERIA FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS

Current eligibility for membership in the Council is determined on the basis of one of the two following criteria:

(a) *Teaching Hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry; and, which are elected by the Council of Teaching Hospitals;*

or

(b) *Those hospitals nominated by an AAMC Medical School, Institutional Member or Provisional Institutional Member, from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals.*

The Ad Hoc Committee recommends that the criteria for membership be revised to read as follows:

ELIGIBILITY

Eligibility for membership in the Council of Teaching Hospitals is determined on the basis that:

(1) the hospital has a documented, institutional affiliation arrangement with a school of medicine for the purpose of significantly participating in medical education;

AND

(2) the hospital sponsors or significantly participates in approved, active residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

REQUIREMENT

(1) Approval by the COTH Administrative Board;

(2) Approval by the AAMC Executive Council

(3) Approval by the AAMC Assembly

PROCEDURE FOR APPLICATION

(1) Application by the hospital with an endorsement by the Dean of the affiliated school of medicine;

OR

(2) Nomination of the hospital by the Dean of the school of medicine.

In the case of specialty hospitals, the Administrative Board shall make exceptions based on the extent to which the teaching hospital meets the criteria within the framework ~~of the specialized~~ objectives of the hospital. It is thus the intent that rehabilitation, psychiatric, children's, and such other specialty hospitals which sponsor or participate in medical education and have institutional affiliations ~~for the~~ purpose of ~~significant~~ participation in medical ~~education~~ are eligible for ~~COTH~~ membership.

By exception, and in unusual circumstances where a hospital has demonstrated a continuing major commitment to medical education, as demonstrated by the range and scope of programs offered, the Administrative Board may waive the requirement for medical school affiliation.

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

APPENDIX B

D R A F T -- For Discussion Purp
JSM-- July 12, 1972

MEDICAL EDUCATION -- THE PATIENT CARE COST COMPONENT

The Committee on the Financing of Medical Education has proceeded with the view that the undergraduate educational program requisite to the qualification of an individual for the M. D. degree is ~~comprised of~~ an integral mix of teaching, research and patient care activity--all three of which are essential to the process. Given this ~~view~~ then, the measurement of the costs of undergraduate medical education requires some method of deriving from the overall teaching, research and patient care expenditures of an academic medical center the propertion and amounts of such expenditures which can appropriately be attributed to undergraduate education.

The Association of American Medical Colleges cost allocation process does provide for distributing instructional costs among the various educational programs, but no firm conceptual approach or methodology has yet been devised for separating research and patient care costs on a program basis. The Research Task Force is engaged in assessing the utility of alternative approaches to the program distribution of

research costs. Similar effort must be directed to the problem of determining what part, if any, of the patient services expenditures of an academic medical center should be considered as applicable to education, specifically undergraduate medical education, and thus be included in the measurement of the costs of such programs.

The approach to the resolution of this problem would appear to involve submitting the total expenditures for hospital and clinic services of an academic medical center to a sequence of three reductions:

1. Teaching Function Costs

The first reduction is relatively straightforward and is already provided for in the AAMC cost allocation methodology. Included here are the costs of those activities financed under the teaching hospital budget of an academic medical center which can be appropriately considered as teaching in nature. This would include, for example, the teaching activities of the nursing and other hospital staff and associated expenses. As noted, methods for determining and allocating the costs of such hospital teaching functions are already a part of the current cost allocation program. Thus these particular costs are being identified and separated in the current cost allocation studies.

2. Incremental Hospital Costs Due To Teaching

The second reduction is conceptually a relatively

clear matter, but there is at present no agreed upon methodology much less an appropriate body of data to carry out the necessary quantification process. Included here are those increased hospital operating costs resulting from the conduct of teaching functions within the clinical setting. This would include, for example, the costs of increased laboratory testing, added hospital days, greater housekeeping costs, etc. which result from the conduct of teaching activities and specifically undergraduate teaching programs. There have been numerous observations of the substantial differences in operating costs between teaching and non-teaching hospitals. The major part of those differences has been considered to be the combined effects of the added costs of teaching functions, the greater expense involved in treating a more seriously ill patient population and the more extensive services provided. Almost nothing has been done in separately measuring these several factors of difference much less making any attempt to distribute these incremental costs due to teaching programs among the several educational programs involved. Advice on how to proceed in carrying out this second reduction is urgently needed.

3. The Sharing of Joint Costs

The third reduction of the patient care costs of an academic medical center in reaching for the full costs of educational programs is principally a conceptual and policy

problem, rather than a methodological one. Described thus far in the preceding steps one and two are those costs encompassed in the patient care expenditures of an academic medical center which result directly, and to a degree indirectly, from the conduct of teaching activities. Carrying out the reductions of these costs, as proposed in steps one and two, would leave as a remainder, those expenditures for what might be termed regular patient care activity shorn of teaching costs.

The question that remains is whether any part of this body of patient care costs should be allocated to the cost of medical education. The reason this question arises is the simple fact that the conduct of an undergraduate medical education program requires access to a particular volume of patient care activity. Without it there can be no medical education program. At the same time that patient care activity is being carried out to provide needed hospital care for sick people and thus serves another objective; namely, providing health care.

Thus, some part or all of the patient care activity of an academic medical center serves more than one objective and therefore constitutes a joint endeavor serving dual purposes. Since this patient care activity is essential to each such purpose, there is reason to argue that its costs ought to be shared to the extent that they are truly joint. (In many instances, the patient care program of an

academic medical center may be of a substantially greater magnitude than that required to provide an adequate teaching program. Such additional patient care activity would be above and beyond that which could be considered as jointly serving educational programs, and its cost would have to be assigned to other program objectives.)

The fact that this regular patient care activity is reimbursable by its recipients or their agents does not change the theoretical problem of how its costs should be assigned. If, indeed, the costs of this regular patient care activity are fully reimbursed that would appear to have the practical effect of eliminating the problem. But, if they are not fully reimbursed, as could be the case if any number of indigent patients, not eligible for public support, are treated, the basic issue remains except that is presented in a somewhat more acute form; namely, who shall bear the burden of the deficit?

The inclusion of this third element of patient care costs related to medical education represents a substantial departure from existing cost measurement approaches. While it may be conceptually valid, it presents major policy considerations, but it does offer the possibility of clarifying and placing on a truly comparable basis, the cost measurement of medical education programs. The methodological process of obtaining this third level of cost involves an agreement on the volume of patient care activity requisite

to the teaching of a specific number of students, i.e. the number of patients or patient admissions per student.

In summary, advice is required on the elements of patient care expenditures in an academic medical center that should be assigned to medical educational and specifically undergraduate education programs and the appropriate methodology for deriving such data.

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

September 14, 1972

AAMC Headquarters
Washington, D.C.

PRESENT: Board Members

Sam L. Clark, Jr., Chairman (Presiding)
Ludwig Eichna
Ronald W. Estabrook
Robert E. Forster, II
Charles F. Gregory
Robert G. Petersdorf
*Jonathan Rhoads
*James V. Warren
William B. Weil, Jr.

Staff

Michael F. Ball
**L. Thompson Bowles
Connie Choate
**John A.D. Cooper
Mary H. Littlemeyer
**Joseph M. Murtaugh
**James R. Schofield
August G. Swanson

ABSENT: Board Members

Ernst Knobil
Louis G. Welt

I. Adoption of Minutes.

The minutes of the CAS Administrative Board meeting held May 18, 1972 were adopted as circulated.

II. Chairman's Report.

Dr. Clark reported on various actions taken since the last Board meeting. Among items of particular interest were the following:

1. The Chairman of the Council of Deans convened a committee on July 11, 1972 to consider medical school admissions problems. The Board requested that minutes of this meeting be circulated. A copy is attached hereto. (ATT. A)

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* Ex Officio
** For part of meeting

2. At its meeting in June 1971, the Executive Council directed the AAMC staff to "explore moving the February meeting to a suitable location in March as soon as possible." An announcement was made at the October meeting of the Assembly that the AAMC would not continue to meet in conjunction with the AMA Congress on Medical Education after its commitment was fulfilled in February 1972.

Several factors precipitated this proposed change. The February date followed too closely after the Annual Meeting (three months), and past history proved that little or no business required Assembly action in February. In addition, members felt that the combined meeting of the AAMC and the AMA Congress required them to be away from their schools for too long a period of time.

3. The Executive Council on May 19, 1972 approved the following policy statement on the establishment of a Cabinet-level Department of Health.

> *The issues confronting this nation in providing a higher level of health and well being to its citizenry are among the most vital and urgent of existing domestic problems. The prospect of some form of universal health insurance coverage will press to the absolute limits our resources and ingenuity to provide health services based on need rather than on arbitrary economic determinants.*
>
> *Since its establishment in 1953, the Department of Health, Education and Welfare has grown into a bureaucracy of 102,000 employees with an overall budget of nearly $79 billion, one-third of the entire federal budget. More than 250 categorical grant programs are operated by the Department, including 40 separate health-grant programs.*
>
> *The present framework within the Department of Health, Education and Welfare subordinates and submerges the health function in a manner which derogates the critical significance of these vitally important issues. There needs to be a single, authoritative point of responsibility for health policy within the federal structure. There needs to be a vigorous national leadership for the evolution of sound federal programs in the health field.*

The President's current Executive reorganization proposal to create a Cabinet-level Department of Human Resources would only further obscure the process of policy formulation in health.

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

III. Action Items.

1. Revised Dues Schedule for submission to CAS Business Meeting, November 3, 1972.

Below are the two options for a dues structure voted on by the Administrative Board at its May 18th meeting (see Page 2 of Minutes). The dues schedule was presented to the Executive Council at its May 19th meeting. The Executive Council made the recommendation that the CAS implement a variation of Option B to avoid having the Business Affairs Office of the AAMC handle reimbursement procedures for transportation of representatives.

CAS Dues Increase

Option A

Membership	# of Soc.	Dues	Yield
Less than 300	28	$ 750	$21,000
300; less than 1,000	10	1,000	10,000

Option A (cont.)

Membership	# of Soc.	Dues	Yield
1,000; less than 5,000	8	$2,000	$16,000
5,000 or more	5	3,500	17,500
TOTALS	51		$64,500

Utilizing the above schedule, one representative from each member society will be provided coach class transportation (no accommodations) to the Annual Meeting of the AAMC. Reimbursement for this transportation would be by the Business Office of the AAMC.

Option B

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

Under this option no transportation services would be provided.

ACTION: On motion, duly seconded, the CAS Administrative Board voted (6 for and 2 against [Drs. Weil and Estabrook]) to recommend Option B at the Fall Business Meeting.

AMENDMENT: Not Accepted — An amendment was offered to the effect that expulsion of a Society requires a vote. This amendment to the motion was not accepted.

AMENDMENT: Accepted — The motion was subsequently amended to specify that ACTIVE members constitute the dues base. A CAS Brief concerning this dated September 18 was distributed to the Membership (ATT. B).

2. Submission of Resolution on Basic Sciences in Medicine to the Council for action.

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.

On May 18, 1972 the Executive Council approved this resolution in principle and agreed that it should be considered by the COD and COTH Administrative Boards and transmitted to the Liaison Committee on Medical Education.

ACTION: On motion, duly seconded, the CAS Administrative Board voted unanimously to put this resolution before the Council of Academic Societies at its fall meeting.

Dr. Swanson was asked to write to the Association of Medical School Microbiology Chairmen to convey the Board's appreciation of their resolution on this matter.

3. Membership applications.

ACTION: On motions, duly seconded, applications for membership in the Council of Academic Societies were approved for the following societies:

1. The Central Society for Clinical Research, Inc.
2. The American College of Psychiatrists
3. Biophysical Society
4. American College of Radiology

4. 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 on human beings 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 earmark a percentage of Federal research funds to the study of the implications of the research, and to prohibit Federal research support unless the human subjects of the research are fully informed of the implications and dangers of the project. 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.

ACTION: On motion, duly seconded, the CAS Administrative Board adopted the following policy statement:

POLICY STATEMENT OF THE AAMC ON THE PROTECTION OF HUMAN SUBJECTS

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

5. Policy of Veterans Administration Relating to Dual Payment of House Staff.

The CAS Administrative Board discussed VA Circular #10-72-184, dated August 15, 1972 on the subject "Coverage in the Admitting Area." (ATT. C)

Drs. Petersdorf and Warren provided information that indicated this had not been a unilateral action on the part of the VA, inasmuch as they both had been involved in prior discussions of the issue. Additionally, this was felt to be a local problem, rather than a national one, which varied

considerably from setting to setting.

ACTION: On motion, duly seconded, the CAS Administrative Board voted unanimously that, the intrinsic issue involved in VA Circular #10-72-184, is not of sufficient magnitude to justify confronting the VA.

Improved communications are expected to result from liaison already established with the VA by Dr. Ball, who will meet with them monthly.

IV. Information Items.

1. Mr. Murtaugh reported on the activities of the Committee on the Financing of Medical Education. Dr. Sprague will make a progress report in the fall. The first report of the Committee is expected by December.

2. Dr. Swanson expects that the National Library of Medicine will award a contract to the AAMC whereby it will, among other things, bring together faculty and CAS representatives for the purpose of identifying, developing, producing, and utilizing biomedical educational materials.

3. Dr. Schofield reviewed the history of the Liaison Committee on Medical Education which is the official accrediting body for undergraduate medical education. Approximately 30 - 35 accreditation visits are conducted annually. By 1973, the number of medical schools is expected to reach 113. By 1975, first-year enrollment is expected to total 15,000 or approximately a 100% increase in 25 years. The increasing societal expectations for M.D. production have resulted in undue enthusiasm from many groups ill-equipped but desirous of starting new medical schools. Accreditation functions include consulting with groups thinking of planning new medical schools. The

problem of increasing the production of physicians must be related to the appropriate use of the physician's time and an equitable geographic distribution of the physicians.

4. An abstract of the COD-CAS Joint Meeting to be held Sunday, November 5, in Miami Beach was reviewed. This session is entitled "Colleges and Medical Schools--Approaches to Accomplishing Their Joint Mission."

Dr. Warren suggested that this program, as presented in the Agenda, be promoted to the CAS full mailing list.

Dr. Forster was enthusiastic about the timeliness of the program planned and asked if speakers were being asked to contribute articles for a symposium issue of the Journal of Medical Education.

5. Dr. Swanson reported on the CAS Workshop on Individualized Medical Curricula originally planned for Spring, 1973. Foundation support is currently being sought. Dr. Swanson was urged to proceed with faculty recruitment, although in the absence of eventual funding, they would be required to pay their own expenses.

Dr. Weil indicated that he would like to see a topic added for discussion of the conflict between the integrated curriculum and the individualized curriculum.

6. Dr. Ball reported on taxability of fellowship stipends. AAMC legal counsel indicated that effective immediately training stipends must be treated as salary and wages and are not excludable from income tax or social security.

7. An AAMC Committee on Graduate Medical Education, chaired by Dr. William G. Anlyan, held its first meeting on July 20, 1972. The Committee will work at the national level on policy matters relating to the Coordinating

Council on Graduate Medical Education and the Liaison Committee on Graduate Medical Education and on problems relating to financing. At the meeting to be held October 4, 1972, a preliminary draft of a structure and functions document will be presented and a generic model for designating when students have achieved a sufficient level of responsibility to be considered junior associates will be presented. At the local level, the Committee will be available for advice and counsel to institutions intending to implement institutional responsibility for graduate medical education.

8. Dr. Warren informed the Board of the official action by the A.M.A. House of Delegates to prohibit students from writing on patient records. The Board agreed that this action runs counter to effective teaching in the clinical setting and asked that Dr. Warren report on and discuss this issue at the Fall CAS meeting.

V. Discussion Items.

1. Dr. Warren reiterated his interest in seeing the Committee on Primary Care activated. A report on programs in primary care or in family practice in the medical schools would be valuable. Dr. Petersdorf supported this idea.

2. Dr. Rhoads suggested the possibility of a workshop which would consider the possibility of a new format of awarding degrees in medicine that would recognize that medical education has multiple functions. To illustrate, Dr. Rhoads said at Level 1, which would be the awarding of the M.D., the generalist would be produced; Level 2, perhaps a Masters degree, a specialist; and Level 3, perhaps a Ph.D. or D.Sc. degree, would recognize the scholar/researcher who had done a thesis.

3. The need to improve the timetable and the mechanical aspects of the National Intern and Residency Matching Program were discussed.

4. The agenda for the fall CAS meeting was outlined.

VI. Other Items.

At the conclusion of the meeting Dr. Clark expressed official appreciation on behalf of the Administrative Board of the Council of Academic Societies to Drs. Rhoads and Warren for their very significant years of service in its leadership.

VII. Adjournment.

The meeting was adjourned at 3:40 p.m.

MHL:smc
9/25/72