

Council of Deans
Administrative Board

AGENDA

9:00 a.m. - 4:00 p.m.
December 14, 1972
Conference Room
AAMC Headquarters

- I. Minutes of the Previous Meeting
- II. Report of the Executive Committee
Retreat - Dr. Mellinkoff
- III. Spring Meeting Program
- IV. Quality of Care Subcommittee Report
-- Next Steps
- V. Progress Report on Management Advancement
Program - Dr. Wilson
- VI. Admissions Committee Report
- Follow-Up
- VII. COD Input to AAMC Priorities
- VIII. Minutes of the OSR Business Meeting
November 2-3, 1972

Luncheon
with CAS, COTH Administrative Boards and SSA Officials
12:00 noon - 1:00 p.m.

- IX. Meeting with SSA Officials
1:00 p.m. - 3:00 p.m.

INFORMATION ITEMS

1. Business Officers Continuing Education
Program
2. Court Order in Admissions Case

I. MINUTES OF THE PREVIOUS MEETING

Association of American Medical Colleges

MINUTES

Administrative Board
of the
Council of Deans

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

PRESENT:

(Board Members)

Carleton B. Chapman, M.D.
J. Robert Buchanan, M.D.
William Mayer, M.D.
Sherman Mellinkoff, M.D.
Emanuel Papper, M.D.
Harold C. Wiggers, Ph.D.

(Staff)

Paul Jolly, Ph.D.
Amber Jones
Joseph A. Keyes
Joseph Murtaugh
Joseph Rosenthal
James R. Schofield, M.D.
Marjorie P. Wilson, M.D.

ABSENT:

Ralph A. Cazort, M.D.
Clifford G. Grulee, M.D.
William F. Maloney, M.D.

I. CALL TO ORDER

Dr. Carleton Chapman called the meeting to order shortly after 12:00 noon.

II. MINUTES OF THE PREVIOUS MEETING

The minutes of the September 14, 1972, Council of Deans Administrative Board Meeting were approved as circulated in the Agenda Book. Dr. Chapman mentioned and received Board approval of a staff suggestion that the Administrative Board meetings be drafted rapidly, approved by the Board members by mail, and distributed to each Council of Deans member.

III. FUTURE MEETING DATES OF THE COUNCIL OF DEANS ADMINISTRATIVE BOARD

The Board approved the proposed schedule of meetings as follows:

| | |
|----------------------|--------------------|
| Administrative Board | December 14, 1972 |
| | March 15, 1973 |
| | June 21, 1973 |
| | September 13, 1973 |

Thus, the Board decided to continue its recently established practice of meeting the day prior to the Executive Council Meetings which are scheduled

for December 15, 1972; March 16, 1973; June 22, 1973; September 14, 1973. It was noted that the December meeting of the Administrative Board will be the last opportunity to discuss the Spring Council of Deans Meeting program at an Administrative Board Meeting.

IV. REVIEW OF THE COUNCIL OF DEANS MEETING AGENDA

Dr. Chapman noted that the document "Profiles of U.S. Medical School Faculty, Fiscal Year 1971" would be available for distribution at the Council of Deans meeting. He indicated that he would mention this in his report as Chairman. A member of the Association staff would be standing by to comment and respond to any questions on the Faculty Roster material.

Dr. Chapman indicated that the minutes of the Subcommittee on the Quality of Care provided as an information item to the Administrative Board would be available for distribution at the Council of Deans meeting. Dr. Weiss, Chairman of the Subcommittee, would report on the deliberations and conclusions of this Subcommittee at the Council of Deans meeting.

The Board then took up the question of COD action on the issue of faculty participation in the governance of the Association. It was agreed that the Council of Deans is committed to taking some stand on the question at this meeting. Dr. Chapman said that he proposed to call on Mr. Keyes to give a brief review of the handling of this issue by the various bodies within the Association. After this report, Dr. Chapman would open the issue for general Council of Deans discussion. Dr. Buchanan discussed the desire of the Deans of the Northeast Region to address the broad issue of additional mechanisms of faculty participation in the governance of the Association, prior to dealing with the specific OFR proposal forwarded to the Council of Deans by the Executive Council of the Association. Dr. Chapman indicated a resolution to that effect at this point in the Agenda of the COD meeting would be in order.

V. SPRING MEETING OF THE COUNCIL OF DEANS

The staff distributed to the membership an outline of the Spring Meeting developed as a result of the deliberations of the Administrative Board at its previous meeting. The Board then proceeded to discuss the program, the speakers to be invited and the instructions to be given to the speakers. The results of this discussion are summarized on the outline of the COD Spring Program appearing as an attachment to these minutes.

The Board members were asked to provide additional comments on instructions to be given to the speakers and to provide suggestions for the series of questions to be posed to each of the small groups as a means of focusing their deliberations.

VI. NEW BUSINESS

Dr. Buchanan related the suggestion of the 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 associated activities. This matter was considered briefly with the Board concluding that the purposes of such a study were inadequately formulated at this time for the Board to make such a request of the Business Officers.

VII. ADJOURNMENT: THE MEETING WAS ADJOURNED AT 1:45 PM

COUNCIL OF DEANS

March 7-10, 1973
 Hilton Palacio del Rio
 San Antonio, Texas

March 7, 1972

8:00-9:00 p.m. REGISTRATION AND RECEPTION

March 8, 1972

8:00-8:45 a.m. INTRODUCTION:

The Objectives of the Meeting

Sherman Mellinkoff, M.D.
 Dean, UCLA School of Medicine

8:45-12:00 noon THE INFLUENCE OF THIRD PARTY PAYERS ON MEDICAL
 EDUCATION AND PATIENT CARE IN THE TEACHING SETTING
SESSION I - THE EFFECT ON FUNDING

Moderator: Ivan L. Bennett, Jr., M.D.
 Vice President for Health and Dean
 New York University School of Medicine

*Should we seek to increase or decrease income
 from hospital care and professional service
 as a source of funding undergraduate and
 graduate medical education?*

"The facts of the matter - current trends"

Martin Feldstein
 Harvard University

Reactor Panel: A.J. Binkert (Presbyterian, NYC)
 Thomas M. Tierney (SSH)
 H. Robert Cathcart (Pennsylvania Hosp.)

Discussion Groups A,B,C,D 9:30-10:30

Coffee Break 10:30-10:45

Plenary Session 10:45-12:00

1:30-5:00 p.m.

SESSION II - THE EFFECT ON FACULTY

Moderator: Bill Drucker or Charlie Sprague

Faculty Practice Income as a current and future source of medical center financing. (Report on survey of Faculty Practice Plans will be available.)

Robert Petersdorf
Chairman of Medicine
University of Washington, Seattle

Reactor Panel: Ann Somers
Hugh Luckey
Jerry Folley
Bill Anlyan

Discussion Groups A,B,C,D. 2:30-3:30

Coffee Break 3:30-3:45

Plenary Session 3:45-5:00

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6:00-7:00 p.m.

RECEPTION

7:00-8:00 p.m.

DINNER - Speaker: Jay Forrester

"World Dynamics"

March 9, 1972

8:30-12:00 noon

SESSION III - THE EFFECT ON THE TEACHING PROGRAM

Moderator: Julie Krevans

Is medical education moving in the direction of the ambulatory setting? What is the cost--in dollars and in quality of educational and care programs?

*Cost and financing implications?
Educational content implications?*

Robert Haggarty
Chairman, Dept. of Pediatrics
University of Rochester

Reactor Panel: Walsh McDermott
Bob Heyssel
Jerry Perkhoff
James Maloney (UCLA)

Coffee Break 9:45-10:00

Discussion Groups A,B,C,D 10:00-11:00

Plenary Session 11:00-12:00

2:00-4:00 p.m.

SESSION IV - DISCUSSION WITH THE PRESIDENT
John A.D. Cooper, M.D.

4:00-4:30 p.m.

Coffee

4:30-7:00 p.m.

SESSION V - A TIME FOR ACTION

Chairman: Sherman Mellinkoff, M.D.

Conclusions and Recommendations

Adjournment

II. REPORT OF THE EXECUTIVE COMMITTEE RETREAT

The attached material is a staff summary of the Executive Committee Retreat prepared for the Executive Council. It is included in this agenda book because it is considered essential background for an informed consideration of other items on the agenda, especially item VII.

REPORT OF THE AAMC OFFICERS' RETREAT

December, 1972

The Chairman and Chairman-Elect of the Association along with the Chairman and Chairman-Elect of each Council, the OSR Chairman and key AAMC staff met from November 30 - December 2 to review the activities of the Association and to set new goals for the coming year.

Foremost among the new priorities established for the Association was a Primary Care initiative. The stated objectives of this program are: 1) development of models for the delivery of primary care by teams of health professionals; 2) implementation of models by medical schools to evaluate effectiveness and train health professionals as a team; and 3) promotion of new models for delivery of primary care in the community. The Retreat participants instructed the AAMC staff to prepare eventually a White Paper on Primary Care, organize an Institute on Primary Care, and seek Federal support for innovative models of primary care delivery.

Other new programs given top priority by the Retreat participants included the launching of an active Coordinating Council on Medical Education, a feasibility study of a medical school applicant matching program, and the involvement of the academic health centers in the determination of quality of care. Specifically recommended was the development of prototype quality assurance programs, efforts to advance quality assessment methodology, and the eventual creation of academic health center PSROs.

The Retreat participants reviewed with considerable interest and commented on a number of recently initiated and ongoing AAMC programs. Of particular interest were the Data Development and Analysis Program and the Management Improvement and Systems Development Program. The Officers concurred in the plan to evaluate thoroughly what data should be collected and disseminated. Also recognized was the success of Phase I of the Management Advancement seminars and the potential value of the AAMC's coordinating role in developing management systems which would be made available to the health centers. It was suggested that the Association better inform the constituency of the advantages of these new programs for the institutions.

The Minority Affairs activities of the Association came under the scrutiny of the Retreat. A statement issued by a small group of minority students at the AAMC Annual Meeting calling for a complete reorganization

Retreat - continued

of these activities was examined and dismissed after the accomplishments of the Association's Office of Minority Affairs were noted. The provision of better preparatory education, beginning at the grammar school level, was seen as the only complete solution to the schools problem of producing a representative number of minority group physicians. In lieu of this solution, special recruitment and retention programs remain necessary.

High priority was also given to the AAMC's expanded activities on behalf of biomedical research and research training. The need to support young investigators was emphasized, along with the vital role of training grants and general research support grants.

Other programs receiving detailed consideration and emphasis included women in medicine, graduate medical education, and expanded activities in the international arena.

Legislative priorities for the coming year were discussed, and AAMC policies needing review or supplementation were identified. Of particular concern was the Association's lack of an aggressive stance on national health insurance. Other concerns centered around funding priorities and the feasibility of a public stance regarding the creation of new medical schools.

In other deliberations, the Retreat participants discussed the implications of HR 1 and what the AAMC might do on the national level to alleviate the potentially disastrous effects on the medical centers. Relationships with other organizations in the health field were reviewed, particularly in terms of the time commitment required to relate to every group desiring a continuing liaison. The Association staff was instructed to present a position paper to the Executive Committee in March detailing the relationship with associations representing the various health professions schools and with the Vice Presidents for Health Affairs.

As a final action, the Retreat approved a proposal presented by Dr. Sprague suggesting that the 1973 Annual Meeting examine the changing role of the physician in the U. S. and abroad. Several international speakers would discuss the experiences of their countries, which would then be related to the American physician. A suggested theme for the meeting would be, "Preparation and Role of the Physician: Comparative Approaches."

Further consideration of Annual Meeting format and speakers was referred to the Executive Committee.

RETREAT AGENDA

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III. SPRING MEETING OF THE COD

The three principle speakers for the program have been invited. Dr. Petersdorf has agreed to make a presentation. Professor Feldstein has declined. Dr. Haggarty has not as yet responded.

Walter McNerney was invited to make the first session presentation in Professor Feldstein's place. He, too, found it impossible to be available for that date. Additional suggestions are needed.

Also needed is a further sharpening of the objectives and intended outcomes of the meeting.

Finally, you will recall that we have envisioned posing a series of questions to focus the deliberations of the discussion groups. This matter will require additional attention at the Board meeting.

COUNCIL OF DEANS

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Dean, UCLA School of Medicine

THE INFLUENCE OF THIRD PARTY PAYERS ON MEDICAL
EDUCATION AND PATIENT CARE IN THE TEACHING SETTING

8:45-12:00 noon

SESSION I - THE EFFECT ON FUNDING

Moderator: Ivan L. Bennett, Jr., M.D.
Vice President for Health and Dean
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*Should we seek to increase or decrease income
from hospital care and professional service
as a source of funding undergraduate and
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"The facts of the matter - current trends"

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Reactor Panel: A.J. Binkert (Presbyterian, NYC)
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Moderator: Bill Drucker or Charlie Sprague

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Chairman of Medicine
University of Washington, Seattle

Reactor Panel: Ann Somers
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Bill Anlyan

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Coffee Break 9:45-10:00
Discussion Groups A,B,C,D 10:00-11:00
Plenary Session 11:00-12:00

2:00-4:00 p.m. SESSION IV - DISCUSSION WITH THE PRESIDENT
John A.D. Cooper, M.D.

4:00-4:30 p.m. Coffee

4:30-7:00 p.m. SESSION V - A TIME FOR ACTION
Chairman: Sherman Mellinkoff, M.D.

Conclusions and Recommendations

Adjournment

IV. QUALITY OF CARE SUBCOMMITTEE REPORT
-- NEXT STEPS

The report of the Subcommittee was distributed at the Annual Meeting in written form. In addition, Dr. Weiss, Subcommittee Chairman, provided an oral report to the Council of Deans.

A series of four recommendation were developed by the Subcommittee:

"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."

These recommendations were considered at the Executive Committee Retreat. The Board should consider whether it has further input into the design of the Association efforts in this direction.

VI. ADMISSIONS COMMITTEE REPORT FOLLOW-UP

The attached material was submitted by the AAMC staff to the Executive Committee at its Retreat and represents the current plan of activity for implementing the recommendations singled out for action by the Council of Deans.

Stephen I. Centner, Principal, Systems Research Group, Inc., Toronto, Canada, has been invited to conduct a conference for the AAMC staff on the topic of "The Dynamics of Student Matching Programs," on December 11, 1972. A brief report of that conference will be given at the Board meeting.

Proposed Implementation of Recommendations of the Council of Deans
Committee to Consider Medical School Admissions Problems

It is proposed that the four specific recommendations adopted by the COD on November 3 be implemented as follows:

Recommendation #1 - "That this work (with premedical advisors) 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 professions."

It is proposed that this be accomplished in part by establishing a new AAMC-sponsored program whereby teams of experienced admissions officers and preprofessional advisors would be available to visit undergraduate colleges with ten or more premedical students and to provide pertinent information and advice directly to both these students and to their counselors.

Further proposals for carrying out these recommendations include:

a) expanding the Medical School Admission Requirements chapter on "Facts for U.S. Students Considering Foreign Schools and Other Alternatives," b) devoting larger portions of The Advisor to this topic, c) amplifying the Student Affairs Information Service responses to inquiries on this matter, d) increasing general AAMC staff work for the Associations of Advisors for the Health Professions (AAHP), and possibly e) helping develop, finance and distribute a proposed "Handbook for Preprofessional Advisors."

Recommendation #2 - ..."that the AAMC staff, with appropriate consultation, prepare the background information (including an annotated bibliography for admissions committee members) ... for the review of the (Administrative) Board (of the COD) prior to general distribution."

It is proposed that this be prepared by staff of DOSA and DEMR, with consultation from the advisory committee assigned to help implement recommendation #4 below. It probably could be ready for review by the COD Administrative Board at its meeting of March, 1973.

Recommendation #3 - ..."to advise each nonparticipating institution to carefully evaluate this process (of ANCAS) and to assess the

-2-

potential utility of AMCAS in assisting in its own admissions process."

It is proposed that this recommendation be utilized as part of the intensive campaign already under way by the Division of Academic Information to increase participation in AMCAS. It is also proposed that AMCAS staff continue to offer consultative services to help the medical schools make optimum use of the program and to reduce costs where possible.

Recommendation #4 - "That the Association President and appropriate staff explore all aspects of the feasibility of a medical school admissions matching program."

It is proposed that an AAMC staff committee, composed of such individuals as Drs. Jarecky and Johnson of DOSA, Dr. Thompson of DAI and Mr. Keyes of the Department of Institutional Development, be assigned the initial staff work. The charge to this committee will include: a) exploration of the feasibility of an admissions matching plan, b) consideration of alternative approaches (e.g. uniform acceptance dates) and c) recommendation of an appropriate advisory committee from the medical schools.

The initial findings and recommendations would be reviewed by additional AAMC staff, including Drs. Cooper, Swanson and Wilson, and by an appropriate advisory committee from the medical schools. Alternatives for the advisory committee include a) a proposed new GSA Ad Hoc Committee on Admissions Problems, including representation from the AAHP and the OSR, and possibly from other AAMC Councils and b) the existing GSA Steering Committee (which consists of national officers, regional chairmen and the OSR chairman) plus possible added representation from AAHP, COD and CAS.

A tentative work plan is outlined below:

- 1) AAMC staff committee prepares draft of feasibility study report.
- 2) Draft reviewed by senior AAMC staff and by advisory committee.

- 3) Progress report discussed at GSA regional meetings.
- 4) Proposed final report reviewed by Administrative Boards of COD and CAS and by the Executive Council.
- 5) Final report to appropriate Councils and groups at Annual Meeting.

If steps 1 and 2 indicate that a matching plan is not feasible, a written explanation to all concerned could eliminate and/or streamline steps 3-5.

At its meeting of November 3, the COD also approved a request from the GSA Committee on the Medical Education of Minority Group Students that "genuine affirmative action" be incorporated in steps to implement the report of the COD Committee on Admissions Problems. Efforts will be made to do this, particularly in the matching plan feasibility study.

VII. COD INPUT TO AAMC PRIORITIES

Several areas identified over the past year as matters deserving the close attention of the Council of Deans have been picked up as AAMC priority items for the coming year. These include Management Advancement, Admissions Problems, and Quality of Health Care Assessment. This portion of the Board agenda is set aside for a consideration of AAMC priorities and those of the Council of Deans for the year ahead. What is it that we are doing or ought to be doing of particular interest to the COD? Are there extant adequate mechanisms, committees and/or procedures for dealing with these matters appropriately?

The Board members of longer tenure will recall the staff practice inaugurated several meetings ago of including within the agenda book a series of information items including reports and minutes of various Association committees, as well as other matters considered of sufficient importance to be brought to the attention of the Board as the "executive committee" of the COD.

To provide an opportunity to pursue any of those matters in greater detail at this time the agenda for those meetings are attached.

AGENDA

Council of Deans
Administrative Board

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

TAB

- I. Minutes of Previous Meeting ----- N
- II. Future Meetings of the Administrative Board ----- O
- 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 ----- P
 - Comments of Dr. Davis Kessner, National Academy of Sciences, Institute of Medicine, Health Services Research Study ----- Q
 - Commission on Quality Health Care Assurance (Senate Committee Report Excerpt)----- R
- 2. "Profiles of U.S. Medical School Faculty, FY 1971"----- S
- 3. Minutes of the September 19, 1972 Meeting Task Force on Cost of Graduate Medical Education and Faculty Practice Plans ----- T
- 4. Minutes of the RMP-CHP Committee ----- U
- 5. Minutes of the COTH Administrative Board Meeting ----- V
- 6. Minutes of the CAS Administrative Board Meeting (without Attachments) ----- W

AGENDA

COD Administrative Board

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

TAB

- I. Call to Order - 9:00 AM
- II. Approval of Minutes, Meeting of May 18, 1972-----A
- III. Organization of Faculty Representatives-----B
- IV. Report of the Ad Hoc Committee to Consider Medical
School Admissions Problems-----C
- V. Item Referred from the AAMC Executive Council:
"Resolution on the Representation of Basic and
Clinical Scientists in Academic Health Centers"-----D
- VI. Council of Deans 1973 Spring Meeting-----E
- VII. Election of Institutional Members-----F

INFORMATION ITEMS

- I. Report of Follow-Up on COD "Phoenix" Resolutions-----G
- II. COD Annual Meeting Program-----H
- III. Schedule of Regional Meetings-----I
- IV. Health Services Advisory Committee Activities-----J
 - A. Minutes of May 31 Meeting
 - B. HMO Development in Academic Medical Centers
- V. Committee on Graduate Medical Education-----K
- VI. RMP-CHP Committee-Minutes of June 15 Meeting-----L
- VII. Draft Agenda for Council of Academic Societies Work-
shop on Individualized Medical Education-----M
- VIII. Summary of Invited Workshop on Modification of
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- IX. Status Report on the Longitudinal Study of
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- X. Report on Recent Internal Revenue Service Rulings
Regarding Taxability of Research Fellowship Stipends-----O
- XI. Report on American Board of Medical Specialties
Action Regarding the NIRMP-----P
- XII. Legislation Report-----Q
- A. Chart on Current Status of Legislation of Interest
to the AAMC
 - B. Testimony of the AAMC
 - 1. Statement before the Republican Platform
Committee
 - 2. Statement on Legislation to Support Training
in Family Medicine, to Provide Assistance for
Medical Libraries and to Support Training of
Public Health Personnel
 - 3. Statement on Legislation to Improve Medical
Emergency Transportation and Services
 - 4. Statement on Legislation to Improve the Health
Care Delivery System
 - 5. Statement on Certain Appropriations for the
Department of Health, Education and Welfare,
Fiscal Year 1973
- XIII. Sex Discrimination and Higher Education-----R
- A. Summary of Provisions in the Higher Education
Act of 1972
 - B. HEW Contract Compliance - Major Concerns of
Institutions
- XIV. Faculty Unionization - Recent Developments-----S

STAFF REPORTS

-Management Advancement Program

DISCUSSION ITEMS

- Executive Council Agenda Items of Particular Interest to
the COD
- A. Liaison Committee Documents-----T
 - 1. Programs in the Basic Medical Sciences
 - 2. Essentials for Education of the Physician's
Assistant

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- B. The Establishment of New Groups-----
- C. The Committee on Financing of Medical Education-----
- D. Policy Statement of the AAMC on the Protection
of Human Subjects-----U

AGENDA

ADMINISTRATIVE BOARD
of the
COUNCIL OF DEANS

May 18, 1972
Noon to 3:00 pm
Lunch
Conference Room
AAMC Headquarters
Washington, D.C.

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| -Follow-up Action | |
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| VI. Planning Future COD Meetings | 9 |
| -Annual Meeting Program | |
| -Spring Meeting Program | |
| -Proposed Workshop on Individualizing Curricula | |

INFORMATION ITEMS

- A. Progress Report on Management Advancement Program
 -Dr. Marjorie P. Wilson
- B. Progress Report of OSR12
- C. Progress Report of BOS13

VIII. MINUTES OF THE OSR BUSINESS MEETING
NOVEMBER 2-3, 1972

The OSR is required by Association Bylaws to

1. Operate under Rules and Regulations approved by the Council of Deans.
2. Report all actions and recommendations to the Chairman of the COD.

As a means of compliance with the second of these provisions the OSR Chairman and Chairman-Elect reported on the OSR Business Meeting in Miami prior to the COD business meeting. In further compliance, the OSR Minutes are attached for the information of the COD Administrative Board.

In order that the OSR be in compliance with the first of the noted Bylaw provisions, it is appropriate that the Board act upon the OSR Rules and Regulations changes adopted at that meeting. These changes appearing on p. 4 and 5 of the OSR Minutes involve: a) the specification of the duties of the OSR Secretary and b) the term of office of the OSR Representatives. The language of these changes are as follows:

- a) Section 4 (Officers and Administrative Board), Article A, Paragraph 3, should be changed to read:

"The Secretary, whose duties it shall be (a) to keep the minutes of each regular meeting, (b) to maintain an accurate record of all actions and recommendations of the Organization, and (c) to insure the dissemination of the minutes of each regular meeting and a record of all actions and recommendations of the Organization, of the organizations contingent to the AAMC Assembly, and of the Organization's representatives on the committees of the AAMC, within one month of each meeting."

- b) Section 3 (Membership). Add:

"C. Each school shall choose the term of office of its representative in its own manner."

ORGANIZATION OF STUDENT REPRESENTATIVES
OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES

BUSINESS MEETING

November 2-3, 1972
Fontainebleau Hotel
Miami Beach, Florida

1. Call to Order

The meeting was called to order by the Chairman, Larry Holly, at 8:15 p.m. on Thursday, November 2.

2. Roll Call

Mr. Holly declared the presence of a quorum.

3. Minutes of the Previous Meeting

The minutes of the meeting of February 3-4, 1972, were approved without change.

4. Agenda

The agenda was challenged because it was felt that the members of OSR had not had sufficient input in determining what items it would include. The procedure for suspending the agenda was explained and the matter was dropped.

5. Nominations

The following OSR members were nominated for OSR offices for 1972-73:

Chairman-Elect: Michael Flacco, Jefferson Medical College
Alvin Strelnick, Yale University School of Medicine
Harris Nagler, Temple University School of Medicine
(Mr. Nagler later withdrew.)

Secretary: Jan Richard Weber, University of Wisconsin Medical School

ACTION: On motion, seconded and carried, the nominee was seated.

Representative-at-Large:

Mark Cannon, Medical College of Wisconsin
John Guercio, Tufts University School of Medicine
Russ Keasler, LSU-Shreveport School of Medicine
Robert Kohn, Cornell University Medical College
Michael Muhm, University of California-Davis School of Medicine
Harris Nagler, Temple University School of Medicine
C. Elliott Ray, University of Kentucky School of Medicine
George Woods, University of Utah College of Medicine

6. Chairman's Report

Chairman Larry Holly discussed the role of the OSR and its potential effect on health care and medical education in the United States. He viewed the Organization as being in a position to "prod with perceptive questions" rather than being a "resolution factory."

7. Regional Reports

The four Regional Representatives gave brief reports of the regional meetings held earlier in the evening. These included announcements of the 1972-73 Regional Representatives to the OSR Administrative Board who had been elected during these meetings. The new Regional Representatives are:

Southern: H. Jay Hassell, Bowman Gray School of Medicine
Northeast: Rob Amrhein, University of Vermont College of Medicine
Western: Patrick Connell, University of Arizona College of Medicine
Central: Dan Pearson, Case Western Reserve School of Medicine

The regional reports were accepted.

8. Committee Reports

- A. Finance - The written report of the Finance Committee was accepted. Members were reminded that the responsibility for providing funds for OSR members to attend OSR meetings falls upon the individual medical schools.
- B. Minority Affairs - It was announced that the OSR Program Session to be held on November 3 would be concerned with minority affairs, and the report of the Minority Affairs Committee Chairman was deferred until that time.
- C. Social Concern - Papers by Steve Helgerson and Steve Bazeley were accepted as printed in the business meeting Agenda Book.
- D. Senior Electives - Information concerning senior electives has been gathered from about 60% of the medical schools; hopefully this material will be collated in the coming year.

9. Resolution on the Interaction of Basic and Clinical Sciences

The OSR discussed the role played by the basic sciences in the teaching of medicine.

ACTION: On motion, seconded and carried, the OSR approved the following resolution:

Modern education of both undergraduate and graduate medical students requires an academic environment which provides close day-to-day interaction between basic medical scientists and clinicians. Only in such an environment can those skilled in teaching and research in the basic biomedical sciences maintain an acute awareness of the relevance of their disciplines to clinical problems. Such an environment is equally

important for clinicians, for from the basic biomedical sciences comes new knowledge which can be applied to clinical problems. By providing a setting wherein clinical and basic scientists work closely together in teaching, research and health delivery, academic health centers uniquely serve to disseminate existing knowledge and to generate new knowledge of importance to the health and welfare of mankind.

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

10. National Intern and Resident Matching Program

The importance of the National Intern and Resident Matching Program (NIRMP) was considered. Concern was voiced over recent reports of violations of the NIRMP honor code, and the ramifications of failure of the NIRMP were discussed.

ACTION: On motion, seconded and carried, the OSR supported the following Executive Council resolution:

Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, the first hospital-based graduate training appointment after the awarding of the M.D. degree should be through the National Intern and Resident Matching Program.

ACTION: On motion, seconded and carried, the OSR adopted the following:

A committee of the OSR shall be appointed to (1) investigate the extent of violations of the NIRMP; (2) report these violations to the proper authorities and to the OSR; and (3) recommend to the OSR means by which undesirable practices may be halted.

11. Information Items

A. The actions of the AAMC Executive Council on the following items were approved:

- 1) "Functions and Structure of a School of the Basic Medical Sciences"
- 2) "Functions and Structure of a Medical School"
- 3) "Essentials for Education of the Physician's Assistant"
- 4) "Guidelines for Sub-Council Organization."

B. It was noted that the semi-annual February meetings of AAMC have been discontinued.

C. Following the precedent established last year, regional meetings of the OSR will be held in conjunction with the spring GSA regional meetings

in 1973. The importance of attendance at these meetings by as many OSR representatives as possible was stressed.

12. Report of the Ad Hoc Committee on the Establishment of a Matching Program for the Redistribution of Health Manpower

The report of this committee was presented in the OSR business meeting Agenda Book. Committee Chairman Hal Strelnick (Yale) briefly explained the report and moved "that the spirit and recommendations of the report be approved and that the Administrative Board and interested OSR members draw up a resolution to present to the AAMC concerning these matters for next year's meeting." The motion was seconded and was then tabled until the close of the Program Session on November 3.

13. Goals and Priorities

Larry Holly explained that the OSR Administrative Board had developed a general statement of OSR goals and priorities which was included in the Agenda Book. This statement is based on notes from the group discussions of this subject during the OSR meetings last February. Discussion of OSR goals and priorities at the regional meetings next spring is encouraged.

14. Release of Information to the Selective Service System

The practices of medical schools concerning dissemination of student enrollment information to local draft boards was discussed.

ACTION: On motion, seconded and carried, the OSR adopted the following resolution:

Whereas participation by medical schools in the military manpower procurement procedure is neither a legal requisite nor a professional responsibility, and

Whereas the release of information on students to outside agencies without the knowledge or permission of the subjects is a violation of individual liberty,

Therefore, be it resolved that the Organization of Student Representatives of the AAMC strongly recommends to the Council of Deans that all member schools refrain from releasing any information to the Selective Service System except at the specific request of each student involved.

15. Medical Education, HMOs, and Student Debt

The rules were suspended to consider resolutions on medical education, Health Maintenance Organizations, and student debt proposed by Jim Hamilton (UC-Davis). Because of the lack of time to study these resolutions, consideration was tabled until November 3 after the OSR Program Session.

16. Amendments to OSR Rules and Regulations

A. Duties of the Secretary - The importance of better communication within the OSR throughout the year was stressed.

ACTION: On motion, seconded and carried, the OSR adopted the following modification to its Rules and Regulations:

Section 4 (Officers and Administrative Board), Article A, Paragraph 3, should be changed to read:

"The Secretary, whose duties it shall be (a) to keep the minutes of each regular meeting, (b) to maintain an accurate record of all actions and recommendations of the Organization, and (c) to insure the dissemination of the minutes of each regular meeting and a record of all actions and recommendations of the Organization, of the organizations contingent to the AAMC Assembly, and of the Organization's representatives on the committees of the AAMC, within one month of each meeting."

B. Term of Office of OSR Members - The problem of continuity within the OSR was discussed.

ACTION: On motion, seconded and carried, the OSR adopted the following amendment to its Rules and Regulations:

Section 3 (Membership). Add:

"C. Each school shall choose the term of office of its representative in its own manner."

17. Remarks of the New Chairman

Kevin Soden, OSR Chairman for 1972-73, reviewed the OSR activities of the past year and outlined his hopes for the future role of the Organization.

18. Guest Speaker - Health Maintenance Organizations

Dr. Walter McClure, a representative of an independent research organization which is studying the feasibility of Health Maintenance Organizations, outlined the issues with which he is involved and expressed his hope that students will contribute to the development of HMO concepts.

19. Guest Speaker - SAMA

Fred Sanfilippo, a representative of the Student American Medical Association, explained SAMA's plans for its National Information Center (NIC), a clearing house of resources and information for medical students. Complete medical school profiles will be compiled by collecting data from medical students. An NIC questionnaire was distributed to OSR members in attendance.

20. Recognition of Past Chairman

By acclamation, the OSR expressed its appreciation to Larry Holly for his many efforts as the Organization's first Chairman.

21. Recess

The meeting was recessed at 12:25 a.m., to be reconvened following the OSR Program Session on November 3.

22. Meeting Reconvened

The meeting was reconvened at 5:10 p.m. on Friday, November 3.

23. Elections

The following OSR officers were elected for the 1972-73 term:

Chairman-Elect: Alvin Strelnick, Yale University School of Medicine

Secretary: Jan Richard Weber, University of Wisconsin Medical School

Representative-at-Large:

Robert Kohn, Cornell University Medical College
C. Elliott Ray, University of Kentucky School of Medicine
George Woods, University of Utah College of Medicine

24. Report of the Ad Hoc Committee on the Establishment of a Matching Program for the Redistribution of Health Manpower - Continued

Committee Chairman Hal Strelnick conducted further discussion of his committee report. It was requested that the word "manpower" be removed from the title of this committee and replaced with another appropriate word.

ACTION: On motion, seconded and carried, the OSR adopted the following:

That the spirit and recommendations of the Report of the Ad Hoc Committee on the Establishment of a Matching Program for the Redistribution of Health Manpower be approved and that the Administrative Board and interested OSR members draw up a resolution to present to the AAMC concerning these matters for next year's meeting."

25. Medical Education and HMOs

Jim Hamilton introduced a resolution with several recommendations concerning medical education. The resolution was divided into five parts; after discussion, all parts were tabled indefinitely.

Jim Hamilton introduced a resolution concerning the role of the AAMC in promoting HMOs. Because of lack of background information, it was requested that data on HMOs be distributed by AAMC to OSR members, and the resolution was tabled until next year's OSR meeting. In the meantime, consideration should be given to this subject at the regional meetings.

26. Adjournment

The meeting was adjourned at 6:10 p.m.

Respectfully submitted,

Jan Richard Weber
Secretary

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM

NOVEMBER 30, 1972

TO: Administrative Board Members - CAS, COD, COTH

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

SUBJECT: Meeting on December 14 with Mr. Tom Tierney, Director, Bureau of Health Insurance, Social Security Administration.

Since all three Administrative Boards will be meeting on Thursday, December 14, arrangements have been made to meet with Mr. Tom Tierney, Director of the SSA Bureau of Health Insurance. The main theme of the session with Mr. Tierney will be future regulations concerning fee payments to supervisory physicians in the teaching setting. As background for this discussion, I have attached copies of the pertinent sections of the House Ways and Means and Senate Finance Committee Reports.

The session with Mr. Tierney will begin with lunch at 12 noon in the AAMC Conference Room and adjourn in mid-afternoon.

Section 227 of Public Law 92-603 (H.R. 1) provides that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis.

There are two exceptions to this provision:

- 1) Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients".
- 2) The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

QUESTIONS

- 1) Concerning implementation of the second exception as stated above, what documentation or other changes in the organization of professional services, if any, will be required?

- 2) Under the second exception to cost reimbursement (on page 197 of the Senate Finance Committee Report) which requires that for two years prior to 1967, and thereafter, all patients were regularly billed for professional services, what is implied by the words -- "all of the institution's patients" (by State or Municipal Law, some institutions were specifically prohibited from billing); "regularly billed"; "reasonable efforts";
- 3) As a result of general principles set forth in the Senate Finance and House Ways and Means Committee Reports, what changes can be expected in policies as set forth in Intermediary Letter #372? Specifically, what is the definition of a physician's office in the context of the statement on page 197 of the Senate Finance Committee Report ... "This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission?"
- 4) Concerning the "private patient" relationship, do the anticipated changes have a similar implementation in the hospital based specialties ... specifically radiology, pathology, cardiology?
- 5) What factors will determine whether "consultations" are on a fee or cost basis? If consultations are on a cost basis, how will cost be calculated?
- 6) On page 197 of the Senate Finance Committee Report, the following is stated: "Also, the OPD of a hospital may organize the provision of and billing for physicians' services in that department differently from the in-patient setting. In such cases, the decision regarding whether cost or charge reimbursement is appropriate should be made separately for in-patients and out-patients. However, if the services are contracted for on a group basis, and Medicare and Medicaid directly or indirectly pay for such services, the normal basis of reimbursement by the two programs would be one of cost if the services are provided by a directly or indirectly related organization." This language is somewhat confusing; under what circumstances, if any, in the teaching setting can an institution bill costs on the OPD, and fees on the in-patient side? Is this possible? How does this relate to the statement that a physician must see the patient in his office prior to admission in order to bill a fee?
- 7) If it is determined that reimbursement for services of teaching physicians should be included under Part A on an actual cost or equivalent cost basis, how will cost be calculated? (Time and effort?)
- 8) On page 198 of the Senate Finance Committee, it states that the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as in-patient or out-patient hospital services. What

types of costs would be allowable under this determination of reasonable cost? Would it be a possibility to use the "indirect cost" formula of NIH for grants and contracts?

- 9) Is it necessary to establish a separate corporation in order to be reimbursed for the "imputed costs" of unpaid volunteer medical staff? What are the anticipated regulations in establishing such corporations, and what will be the limitations on the uses for which these funds may be expended?
- 10) Concerning experiments and demonstrations under Section 222 (D), how many dollars will be available, or what are the prospects for experiments for a single combined rate of reimbursement for teaching, supervision, and patient care in the teaching setting?

SENATE FINANCE COMMITTEE REPORT

to a reasonable proportion of charges for the initial visit and to limit charges recognized for visits on the same day to a number of patients in the same institution to amounts that are reasonable in relation to the time usually spent and services provided under such circumstances. Of course, such limitations would not preclude individual consideration of requests for higher allowances where such followup visits or multiple visits are justifiable as being nonroutine.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs after enactment of the bill may not be made with respect to any amount paid for items and services which exceeds these new limits. This would be consistent with policy in the present medicaid program.

The medicaid provisions of the Social Security Amendments of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually have set some type of limits of their own, typically less than usual or customary charges. The Social Security Amendments of 1967 added a new medicaid provision which required that a State plan must provide assurances that "payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

On November 11, 1971, HEW issued regulations which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The regulation stipulated that in no case could payment exceed the highest of:

(1) Beginning July 1, 1971, the 75th percentile of customary charges in the same localities established under title XVIII during the calendar year preceding the fiscal year in which the determination is made.

(2) Prevailing charge recognized under part B, title XVIII for similar services in the same locality on December 31, 1970.

(3) Prevailing reasonable charge recognized under part B, title XVIII.

Under the House bill, the Health Insurance Benefits Advisory Council is directed to study the methods of reimbursement for physicians' services under medicare and to report to the Congress by July 1, 1972, on how these methods affect physicians' fees, the extent to which they increase or decrease the number of cases for which physicians accept assignments, and the share of total physician charges which beneficiaries must pay. It is clear, however, that the group will be unable to complete the study requested by the House by July 1, 1972. The committee has therefore extended the deadline to January 1, 1973 so that HIBAC may comply with the House request.

The proposed amendment is substantially along the lines of the present regulation, and would be effective upon enactment.

Payment for Supervisory Physicians in Teaching Hospitals

(Sec. 227 of the bill)

When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of

how medicare should reimburse for the services of a physician when supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

In the typical community hospital and other teaching settings where patients are expected to pay fees for these services, fee-for-service payment for physicians' services would continue to be made by the medicare program. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

To deal with these problems, H.R. 1 as passed by the House and approved by the committee, contains a provision, originally developed by this committee in 1970, which would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. The committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervision on a regularly scheduled basis to nonprivate patients. Such services would be reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Medicare payments for such services would be made available on an appropriate legal basis by the fund to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

1 - Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physicians. To facilitate efficient administration, a presumption may be made that all of the patients in an institution, or portion of an institution, are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements for care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

It is recognized, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services.

In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers. Also, the outpatient department of a hospital may organize the provision of and billing for physicians' services in that department differently from the inpatient setting. In such cases, the decision regarding whether cost or charge reimbursement is appropriate should be made separately for inpatients and outpatients. However, if the services are contracted for on a group basis, and medicare and medicaid directly or indirectly pay for such services, the normal basis of reimbursement by the two programs would be one of cost if the services are provided by a directly or indirectly related organization:

2 - The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in

whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

The committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Another provision in this section would permit a hospital to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. In order to receive reimbursement the hospital would be required to pay the reasonable cost of such services to medicare patients to the institution that bore the cost. The committee expects that such costs will be reimbursable only where there is a written agreement between the hospital and medical school specifying the types and extent of services to be furnished by the school and disposition of any reimbursement received by the hospital for those services.

This amendment would be effective with respect to accounting periods beginning after December 31, 1972.

Advance Approval of Extended Care and Home Health Coverage Under Medicare

(Sec. 228 of the bill)

Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The posthospital home health benefit is payable on behalf of patients

(2) *Payment under medicare for services of physicians rendered at a teaching hospital.*—When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions,

even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

Your committee does not question the appropriateness of fee-for-service payment for physicians' services in the typical community hospital and other teaching settings where patients are expected to pay fees for these services. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

Therefore, your committee's bill would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. Your committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervisory voluntary service on a regularly scheduled basis to nonprivate patients. Such services would be billed for by the organized medical staff of the hospital and reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which would otherwise have to be obtained through employed staff on a reimbursable basis. Such funds would in general be made available on an appropriate legal basis to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when

expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

There are also teaching physicians whose compensation is paid by a medical school. With respect to reimbursement for their direct or supervisory services for nonprivate medicare patients, payments should be made on the basis of actual or salary-equivalent costs. The funds so received may be assigned by such physicians to an appropriate fund designated by the medical school for use in compensating teacher physicians, or for educational purposes. Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' service were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

Your committee recognizes, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services. Furthermore, in some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

Your committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

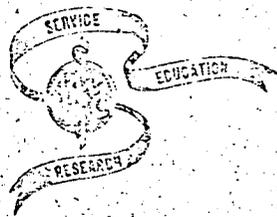
Your committee's bill also provides that the law be amended so that a hospital could include the actual reasonable costs which an affiliated medical school incurs in paying physicians to provide patient care services to medicare patients in the hospital. The bill would also permit including in a hospital's reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. The hospital would be required to pay the reasonable cost of the services in question to the institution that bore the cost.

The above provisions would become effective with respect to accounting periods beginning on or after July 1, 1971.

INFORMATION ITEM - 1.

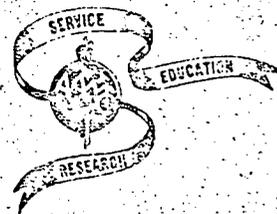
Business Officers' Continuing Education Program

At the February Meeting of the Board, the plans of the BOS for a series of workshops to be conducted at the Annual Meeting were reviewed. Attached is a copy of the schedule of workshops and speakers as well as a list of registrants at the program conducted at the Eden Roc Hotel, October 30 - November 2, 1972. This is presented for the information of the Board by way of follow-up to its previous deliberations.



Continuing Education Program

Business Officers
Section
Council of Deans
of the
Association of American
Medical Colleges



EDEN ROC HOTEL
MIAMI, FLORIDA
October 30-November 2, 1972

The Professional Development Committee of the Business Officers Section of the Council of Deans announces its first national program for continuing education. This program, a culmination of two years of planning, is designed not only to play a significant role in the communication of information and ideas among business officers and associates affiliated with medical schools across the country, but also to be of value to other administrators and staff officers in the nation's health centers.

Registration is open to all interested parties.

**Business Officers Section
Association of American Medical Colleges**

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Training Program Management
New York University Medical Center

Chairman-elect

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University of Miami School of Medicine

Lauren W. Blogg
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University of Utah College of Medicine

V. Wayne Kennedy
Assistant Dean for Fiscal Affairs
University of Maryland School of Medicine

Marshall W. Smith
Assistant to the Dean
The Abraham Lincoln School of Medicine, Chicago

Daniel P. Benford
Executive Assistant to the Dean
Indiana University School of Medicine

General Information

Fee

The registration fee for the workshop is \$75.00. Included are the costs of instruction, conference materials and coffee breaks.

Registration

Registration will take place Monday, October 30, 1:00-6:00 p.m. at the Eden Roc Hotel. Please return the enclosed registration form as soon as possible, but not later than September 1, 1972.

Lodging

Lodging accommodations will be available at the Eden Roc Hotel, 4525 Collins Avenue, Miami, Florida, 33140. Rates are \$18-21-24-28 for single or double occupancy. Early registration is urged to assure accommodations at the workshop site. A hotel registration form is enclosed.

For Additional Information, Write:

Marvin H. Siegel
Asst. Business Manager for Medical Affairs
University of Miami School of Medicine
P.O. Box 875, Biscayne Annex
Miami, Florida 33152

Program

Monday, October 30

- 1:00- 6:00 p.m. Registration—Schedule of class assignments will be available at registration.
6:30- 8:00 p.m. Reception with cash bar

Tuesday, October 31

- 8:30- 9:30 p.m. General Assembly
Welcome—Marvin H. Siegel
Introduction of faculty and keynote speaker—Thomas A. Fitzgerald
Keynote address—Daniel Robinson
9:45-11:00 a.m. Class Period #1
11:15-12:30 p.m. Class Period #2
12:30 - 2:00 p.m. Lunch—Free Period
2:00 - 3:15 p.m. Class Period #3
3:15 - 3:45 p.m. Coffee
3:45 - 5:00 p.m. Class Period #4

Wednesday, November 1

- 8:30- 9:00 a.m. General Assembly
9:15-10:35 a.m. Class Period #1
10:45-12:00 p.m. Class Period #2
12:00 - 1:30 p.m. Lunch—Free Period
1:30 - 2:45 p.m. Class Period #3
2:45 - 3:00 p.m. Coffee
3:00 - 4:15 p.m. Class Period #4

Thursday, November 2

Annual Meeting of the Business Officers Section

Description of Courses

Financial Reporting for Health Centers

John N. Ballow

The purpose of this course is to acquaint medical school business officers with background on the makeup of the formal financial statement of the medical school and other units in the health center. It is designed to give business officers an approach for understanding the relationship and consolidation of the health center's financial statement with those of the parent university, as well as their usefulness to various levels of management as management tools. A discussion will be held on the possible conflict arising from the use of College and University Business Administration text (revised edition, 1968) as a source for university accounting when related to procedures required in accounting for health center programs and activities.

Budgeting Techniques

Ronald E. Beller, Ph.D.

During the course suggestions will be made for procedures to comprise a complete budget cycle, including preparation, presentation, implementation and control. In addition there will be discussion of medical school and medical center budget techniques being used. Another aspect will be consideration of categories of funds and how these funds should be controlled and considered in the budget system.

Supervision and Human Relations

Milton F. Droege Jr.

How has the mediocre economy of the past two years affected the style of management in business. Is it likely to last? How is it reflected in our colleges and universities? Will the oversupply of teachers and spiraling costs affect the work atmosphere of the business manager? These are some of the problems that will be tackled in the decade of the seventies during which there will be restructuring of the methods and systems necessary to change ever changing goals within the academic setting.

Management Information Systems

Edgar Lee, M.D.

Kenneth L. Kutina

Important in this course will be its coordination with and complementation of previous BOS Seminars on the Integrated Medical Center Information System (IMCIS) through a discussion of those informational needs viewed as being most critical to managerial decision making at one academic medical center. The primary fabric for arriving at specific information requirements, as well as effectively utilizing the resultant data base, is a model-aided system for program planning and budgeting with feed back control.

Sponsored Program Administration

Doris H. Merritt, M.D.

Discussion in this course will cover the important administrative aspects of sponsored programs within medical schools and medical center complexes. Special attention will be given to the philosophy and techniques of developing grant applications, financial and scientific review, fiscal and administrative management of programs and special problems such as effort reporting and use of human volunteers in research.

Administrative and Financial Relationships between Medical Schools and Hospitals

Matthew F. McNulty Jr., Sc.D.

Medical school business officers are to become acquainted with a knowledge of the different types of relationships which exist between medical schools and hospitals as well as their objectives and purposes as relates to emphasis, style, personality and other organizational interaction elements. The course will identify potential problem areas and emphasize techniques for improving communications between these organizations. There will also be a discussion of mutual concerns such as house officer training, bed allocation, support of educational and research programs in the hospital, faculty salaries, etc.

Business Systems and Procedures—New Trends

George M. Norwood Jr.

This course will provide an overview of the various standard business systems which are used in management of medical schools and the complex medical center facilities. Information and discussions will include the identification of new procedures which are being utilized and the future trends anticipated in the changing patterns of medical center business affairs.

The Department of Health, Education and Welfare—Organization and Operations

Richard L. Seggel

This course is to present to business officers of medical schools a knowledge of the organization and operations of the Department of Health, Education and Welfare. Description of major programs and activities of HEW will be presented that have a significant impact on the nation's medical schools. Another focus will be on the processes involved in arriving at decisions on funding within the Executive and Legislative branches of the federal government and the interrelationships between them. This includes the scientific and technical as well as political, policy and administrative considerations.

Participating Staff

Keynote Speaker

Daniel D. Robinson, C.P.A.

**Partner,
Peat, Marwick, Mitchell and Company
New York, New York**

Mr. Robinson, who received his B.S. in accounting from New York University, is in charge of Peat, Marwick, Mitchell and Company's nationwide education and other institutions practice.

Since joining the firm in 1964, he has conducted accounting, auditing and management consulting engagements in New York and in other parts of the country. He is a member of the New York State Society of Certified Public Accountants and the American Institute of Certified Public Accountants, as well as other professional and scholastic societies. He is also chairman of the AICPA's Committee on College and University Accounting and Auditing.

Mr. Robinson was formerly with New York University as vice president for business management. During more than eight years at the university he also served as business manager, controller and director, Planning and Procedures. Previously he had gained wide public accounting experiences as an in-charge accountant.

John N. Ballow

**Controller of New York University
Medical Center
New York, N.Y.**

Mr. Ballow, who earned his B.S. in Business Administration from Manhattan College, has held his present position since 1962, after being promoted from assistant controller. Before joining the Medical Center, he was employed with a major public accounting firm for 11 years. During this period, he conducted auditing assignments in educational and health service institutions. Mr. Ballow is a member of

several associations including the Hospital Financial Management Association. For three years he served as a member of the Board of Directors of the Metropolitan New York Chapter of that association. He is also a member of the Hospital Controller's Association of New York and serves as financial representative for his institution in its membership in the Associated Medical Schools of New York and New Jersey.

Ronald E. Beller, Ph.D.

**Assistant Professor of Management
Babcock Graduate School of Management
Wake Forest University
Winston-Salem, N.C.**

Formerly, Dr. Beller was assistant professor of Hospital Administration and head of Budgeting Services for the J. Hillis Miller Health Center at the University of Florida. In this position he was responsible for budgeting and fiscal analysis for the entire Health Center, as well as serving as chairman of the committee charged with establishing a program planning and budgeting system for the Florida health center.

Milton F. Droege Jr.

**President
Management Training Institute
Tulsa, Oklahoma**

Mr. Droege directs the activities and participates in the presentations of the Management Training Institute (MTI). His academic background includes a B.S. in economics and a M.S. in industrial communication, both from Purdue University. His business background includes extensive exposure to data processing, finance and management consulting. He has spoken before numerous associations as well as in the corporate programs conducted by MTI.

Edgar Lee, M.D.

**Associate Dean for Administration
Assistant Professor of Pathology
Case Western Reserve University School of Medicine
Cleveland, Ohio**

Dr. Lee, who received his M.D. from the University of Virginia, has a professional interest in the application of modern management techniques in the analysis of health education, research and service organizations. This interest was shown in 1960 when he was awarded a special commendation of the National Advisory Health Council for his role in the establishment of the Clinical Research Facilities grant program. Also, throughout his career, Dr. Lee has engaged in various research and grant programs as well as perform administrative duties such as in his present position.

Kenneth L. Kutina

**Director of Operations Planning and Analysis
Associate, Division of Research in Medical Education
Case Western Reserve University School of Medicine
Cleveland, Ohio**

Mr. Kutina received his M.B.A. in economics and statistics from Western Reserve University. Besides his present position, he held a series of staff positions with the Standard Oil Company (Ohio) in the field of operations research from 1960-1968. For part of that time (1961-1964), he was a lecturer in statistics at Western Reserve University. Also, Mr. Kutina is a member of several honorary and professional societies including Beta Gamma Sigma and the Operations Research Society of America.

Doris Honig Merritt, M.D.

**Dean for Research and Advanced Studies
Indiana University-Purdue University
Indianapolis, Indiana**

Dr. Merritt, who received her M.D. from George Washington University, has extensive experience in the area of sponsored program administration. In 1961, she became associated with Indiana University as director, Medical Research Grants and Contracts, and has had various appointments at the school in this area. She assumed her present position in May 1971. She has also served as a consultant to the United States Public Health Service, National Institutes of Health, National Heart Institute, American Heart Association, the Indiana State Medical Association and the National Library of Medicine. Dr. Merritt is also active in community activities. She is chairman, Consortium for Urban Education in Indianapolis, and member of the board and executive committee, Community Addiction Services Agency, Inc.

Matthew F. McNulty Jr., Sc.D.

**Vice President for Medical Center Affairs
Georgetown University Medical Center
Washington, D.C.**

Dr. McNulty, a professor of Community Medicine and International Health, Georgetown University, has served in many administrative and academic posts in the hospital and academic health science fields. These posts include associate director, Association of American Medical Colleges; director, Council of Teaching Hospitals; dean, School of Health Services Administration, University of Alabama; general director of hospitals and clinics, and professor of both health administration and preventive medicine and epidemiology, University of Alabama. Now a visiting professor at several universities, he is a noted hospital and health science consultant to state and federal government agencies, and to academic and health field organizations.

George M. Norwood Jr.

**Vice President for Planning
Thomas Jefferson University
Philadelphia, Pennsylvania**

Since 1954, Mr. Norwood, who was graduated from the University of North Carolina with a B.S. in chemistry, has been associated with medical and academic institutions in the area of business, finance and planning. While associated with the University of North Carolina he was credit manager, North Carolina Memorial Hospital, and later named chief fiscal officer, and for eight years served as business officer, Division of Health Affairs. In 1965, he was named vice president for business and finance (treasurer) at Thomas Jefferson University and he was named to his present position in 1970. He has also served as a consultant to various medical-academic groups.

Richard L. Seggel

**Deputy Assistant Secretary for
Health Policy Implementation
Department of Health, Education and Welfare**

In his position, Mr. Seggel is the principal assistant to Dr. Merlin K. Duval, assistant secretary for health and scientific affairs, on policy matters relating to day-to-day operations encompassing the three health agencies of HEW—the Health Services and Mental Health Administration, National Institutes of Health, and the Food and Drug Administration. He is responsible to the assistant secretary for: resolving operations problems; insuring that established policies are carried out through the budget, program planning and legislative processes; evaluating and advising on the effectiveness of programs, and making recommendations on budgetary and management policy.

BUSINESS OFFICERS SECTION
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
CONTINUING EDUCATION PROGRAM
MIAMI BEACH, FLORIDA
OCTOBER - NOVEMBER - 1972

KEYNOTE SPEAKER

Daniel D. Robinson, C.P.A.
Partner

Peat Marwick Mitchell and Company

HONORARY GUEST

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

University of Miami School of Medicine

FACULTY

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Controller

New York University Medical Center

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and Special Assistant to the
University President

University of South Alabama

Milton F. Droege, Jr.
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Management Training Institute

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School of Dental Medicine

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INFORMATION ITEM - 2.

The attached document is the full text of the Order and Judgment of the Colorado District Court in an admissions decision case involving a claim of discrimination on the basis of sex.

IN THE DISTRICT COURT IN AND FOR THE

CITY AND COUNTY OF DENVER AND

STATE OF COLORADO

Civil Action No. C25921

LINDA A. EMERY,

Plaintiff,

vs.

STATE OF COLORADO; HOPE
LOWRY, M.D.; ROBERT ALDRICH,
M.D.; FREDERICK P. THIEME;
DAVID W. TALMADGE, M.D.;
UNIVERSITY OF COLORADO; and
THE BOARD OF REGENTS OF THE
UNIVERSITY OF COLORADO, a
body corporate,

Defendants.

ORDER and JUDGMENT

APPEARANCES:

MARTIN P. MILLER, Attorney at Law, and
PETER H. NEY, Attorney at Law, appearing
for the Plaintiff.

JOHN P. HOLLOWAY, Assistant Attorney
General, appearing for the Defendants.

This action was commenced by a complaint filed by the Plaintiff alleging that she is a resident and citizen of the State of Colorado, and that she duly made application for admission to the University of Colorado School of Medicine for the fall term of 1971; that she had met all necessary standards to qualify to be admitted to such school, that she was denied admission to said school, and that such non-admission was illegal and unconstitutional for the reason that the policies of the school are such that it had established a systematic exclusion of women as students in the Medical School. The unconstitutional assertion is bottomed on the denial of equal protection of the laws as guaranteed by Article XIV and by the due process clause of the Fourteenth Amendment to the United States Constitution, and by Article II, Section 25 of the Colorado Constitution.

The Plaintiff further alleged that she was discriminated against for admission to such school because she had, at the time of the application, two children, and that the policy of the school is discriminatory since it denies admission to female applicants who are mothers.

The Plaintiff further alleged in her complaint that the school deliberately, indiscriminately and intentionally limits the number of women enrolled in its classes to a proportion which is far less than the actual number of women in the population as a total.

The Plaintiff also alleged that the Defendant Medical School has a policy which discriminates against women generally because of their sex, and particularly against her, not only because of her sex but because she is a mother, and that she was not afforded the same rights and privileges as male applicants. The complaint alleged other tangential grounds of discrimination which were abandoned in the trial on the merits.

The Plaintiff sought relief from the Court in the nature of mandamus, directing the Defendants to admit the Plaintiff to the University of Colorado Medical School; for an order declaring the policies of the Board of Regents which discriminate against women unconstitutional and unlawful; and an order directing the Defendants to cease and desist from any discrimination based upon sex.

The complaint or posture of the Plaintiff's case was modified somewhat by the opening statement of Mr. Martin Miller, the attorney for the Plaintiff, in that he focused Plaintiff's claim in two particular specific areas. First, that the Defendants had engaged in and carried out a policy of systematic exclusion of women in its application and admission procedures at the University of Colorado Medical School, and that such policies and procedures were discriminatory to female applicants as a whole, and particularly to the Plaintiff, who not only is a female, but is married and had children, and that the discriminatory practices as they were applied to her constituted unconstitutional behavior on the part of the Defendants.

Secondly, that the University of Colorado Medical School increased its admissions quota from 105 to 115 in 1969, and again for the 1971 class from 115 to 125, in order to accommodate minority and disadvantaged students, and that for such minority and disadvantaged students the Admissions Committee of the school was encouraged to waive certain qualifications for admission in order to enroll students in this category, and that the Plaintiff, as a female, was a member of such minority or disadvantaged group and as a consequence should have been given the same preference for admission as the other minority or disadvantaged groups.

The presentation of this case, with the taking of testimony and arguments of counsel, consisted of three full days of trial, resulting in 360 pages of testimony. It was stipulated by and between counsel, and accepted by the Court, that the number of females in the population of Colorado is approximately 51 percent of the total population, as determined by the last census.

Witnesses of import who testified were Dr. Hope Lowry, Chairman of the Admissions Committee of the University of Colorado School of Medicine; the Plaintiff, Linda A. Emery; Dr. Robert Aldrich, Vice President for Health Affairs of the University of Colorado; Dr. Frances Norris, a pathologist from Washington, D.C., who held herself out as an analyst on the question of females admitted to medical schools in the United States, and who testified before a subcommittee of the United States Congress on that subject.

The evidence disclosed that the University of Colorado School of Medicine is the recipient of federal funds for part of its support and maintenance, and that

pursuant to a directive of the Department of Health, Education and Welfare, in April of 1969, the Regents of the University were ordered to give special consideration to certain ethnic groups denominated as minority groups and consisting of the following categories as determined by such agency: Chicanos, Blacks, Orientals and American Indians. Such directive applied also to the employment policies of the University of Colorado.

The effect of the directive was that persons in such minority group categories were to be given special consideration for admission to the Medical School, and that in the event the minority group applicants could not meet the qualifications established by the Medical School for admission, then such standards were to be lowered for such minority group applicants, and after their admission those students were to be afforded remedial programs by which they were given special studies and tutorial assistance in order to raise their academic achievement to the norm, thus attempting to fill the gap in their academic deficiencies and to bring them up to the standards required by the Medical School. The minority group categories as established by the Department of Health, Education and Welfare were considered to be educationally, socially and culturally disadvantaged, and in some instances economically disadvantaged.

The Regents of the University of Colorado, by a policy statement, conformed to the directive of H.E.W. and issued mandates of their own in order to comply with such policy, one of which was to encourage and solicit applicants in such minority groups to the Medical School. The policy directed the Admissions Committee to comply with that part of the H.E.W. directive concerning the lowering of admission standards and the institution of remedial measures when required.

The evidence further disclosed that in order to comply with the H.E.W. directive and the policy of the Regents as aforesaid, the 1969 class was increased from 105 to 115, and the 1971 class was increased from 115 to 125, thus adding ten additional places in the Medical School freshman class to make space for the admission of the minority group students.

The evidence further disclosed that a concerted attempt was made to comply with the directive relative to minority group applicants. However, for the 1971 freshman class only four of such minority group applicants were received into the Medical School, and the remaining six places which were not filled by such minority group applicants were filled by other non-minority group applicants who were on the waiting list, all of whom were Colorado residents. The Plaintiff was not qualified, in the opinion of the Admissions Committee, to be placed on such waiting list and thus was not considered for acceptance to fill one of the remaining six places for that year.

At the same time that this matter was heard before the Court, the Plaintiff was enrolled as a law student at the University of Denver College of Law.

From the evidence, the Court makes the following findings of fact.

FINDING NUMBER ONE: That the Plaintiff failed to establish the burden of proof incumbent upon her that women are a member of a minority group and thereby disadvantaged, pertaining to her claim for relief in the instant case.

The categorization of minority groups as applied to admission to the Medical School was not amorphous or without specific delineation to the ethnic delineations. The demarcations establishing the minority groups were specific as to ethnic backgrounds, did not evolutionize from experience in the University of Colorado solely;

they were specifically established, designated, delineated and categorized by the federal government through its Department of Health, Education and Welfare and were specified by that agency, and those ethnic classifications were binding upon the Regents in the formulation of their policies relative to the admission of disadvantaged persons. To reiterate, those minority groups specified by H.E.W. were Chicano, Black, Oriental and American Indian. The Regents did not establish the categories.

It was pursuant to the pre-established minority group categories that the Regents of the University of Colorado issued their policy statement directing that such ethnic groups be given special consideration for admission and for remedial assistance. Despite valiant efforts on the part of Mr. Miller to prove that the federal government had included females in the minority group category, he was unable so to do, and the evidence does not support the conclusion that females are regarded by the government as a member of the minorities. He was successful, however, in his attempt to show that the federal government, through civil rights legislation, demands that females be treated equal with males, and that there should be no discrimination as between sexes.

FINDING NUMBER TWO: That the Plaintiff has failed to sustain her burden of proof that the Plaintiff was discriminated against as a female in her application for admission to the University of Colorado Medical School for the class of 1971.

The testimony was replete with citation of statistics, some of which seemed to be conflicting, and from the labyrinth of such statistical information it was extremely difficult to draw conclusions. However, the evidence did establish the following facts: that the Admissions Committee of the University of Colorado School of Medicine, during all times pertinent herein, used four standards in determining admission to the school, (1) college grade point average; (2) scores on medical college aptitude test (MCAT), and in conjunction therewith special emphasis on that part of the test pertaining to science; (3) recommendations concerning the applicant; and (4) impressions gained from personal interviews.

As respects college grades, the evidence showed that out of a possible 4.00, the average grade point averages were as follows: for male applicants, 3.28; female applicants, 3.52, for a total average of all applicants, both male and female, of 3.31. The Plaintiff's cumulative GPA for the class of 1971 was 2.96. Of importance is the fact that 24 applicants with lower GPA scores than the Plaintiff were admitted to the class of 1971, 17 of whom were white males, 16 minority group males, and one minority group female.

With respect to the medical college aptitude test, with special emphasis placed upon the science section of such test, the Plaintiff's score was 455 out of a possible 800, which score placed her in the bottom or fourth quartile of all applicants to medical schools in the United States. No figures were forthcoming specifically for the University of Colorado. However, the MCAT is a national test required of all applicants to medical schools in the United States, thereby obviating the necessity of such calculation.

Significantly, in this category six students were admitted to the Medical School with lower science section scores, and three with the same science section score as that of the Plaintiff. The statistics deduced that there were four students admitted to the class of 1971 who had both GPA and science section scores on the MCAT as low or lower than the Plaintiff, three of whom were minority group applicants and one white male applicant.

FINDING NUMBER THREE: The evidence disclosed that the University of Colorado School of Medicine, through its Admissions Committee, did not act arbitrarily or capriciously in its refusal to accept the Plaintiff as a student in the 1971 freshman class.

It is obvious from the foregoing that considering the standards established by the Admissions Committee, the ranking and rating of the Plaintiff with regard to such standards, and the comparison of the Plaintiff with other applicants, and the interplay of the discretion that is required of an admitting agency, the Admissions Committee did not abuse its discretion in rejecting the Plaintiff's application.

As concluded, supra, the Plaintiff did not sustain her burden of establishing that she should be given preferential consideration as a female in the status of a minority and disadvantaged individual. It is interesting to note at this point that the witness called by the Plaintiff, Dr. Norris, testified that in her opinion the female applicants for medical school were definitely not disadvantaged, but were superior to male applicants, and that the public was being deprived of a better quality of medical practice because more women were not members of the profession.

The totality of the evidence discloses that the Plaintiff was given fair consideration in her application for admission. The evidence disclosed that when the same standards and factors are applied equally to the Plaintiff, as well as to the other white female applicants, and as well as to male applicants, the Plaintiff was found deficient in meeting the standards for admission. To admit the Plaintiff and reject other more qualified female applicants would be in fact discriminatory against such female applicants. To admit the Plaintiff and to reject more qualified male applicants would in effect discriminate against such male applicants.

The evidence exemplified that regardless of the Plaintiff's grading on any one of the four standards used by the Admissions Committee, she did not qualify on the totality of all four standards with other non-minority male and female applicants.

With respect to the Plaintiff's consideration for the 1972 class, Dr. Lowry testified that the Plaintiff's grade point average had "fallen rather markedly," in that the last eleven hours of premedical science course work showed an average of 2.36, which grade point average excludes a person from consideration for admission to medical school when such person is not a minority group student. Dr. Lowry admitted that if the Plaintiff were a member of a recognized minority group she would have been considered as a candidate for the remedial program as afforded to such minority groups. She further testified that the Medical School refused admission to many white women for the 1972 class who had higher grade point averages and scores than the Plaintiff.

FINDING NUMBER FOUR: The Court finds that there exists in fact an under-representation of females in the University of Colorado School of Medicine and in the medical schools of the nation.

Statistics that were presented definitely established that in proportion to the population as a whole the number of females making application to the Colorado University School of Medicine and to medical schools nationally is disproportionate. However, the above conclusion is reached with the awareness that, as has been indicated, the percentage of female applicants and applicants admitted is on the ascendancy and that a greater percentage of females are applying to medical schools and are being admitted over that of male applicants and applicants admitted.

The Court also finds that there is an under-representation of females in medical schools, as well as in the medical profession, in Colorado and in the nation generally.