AGENDA
COUNCIL OF DEANS ADMINISTRATIVE BOARD
Thursday, June 21, 1973
AAMC Conference Room
9:00 A. M. - 3:00 P. M.

I. Call to Order

II. Approval of Minutes ---------- Tab Q

III. Chairman's Remarks

IV. Consideration of Follow-up Action on the San Antonio Resolution ---------- Tab R

V. AAMC Policy Statement - The Patient in the Teaching Setting ---------- Tab S

VI. Review of the Closeout of the Freestanding Internship ---------- Tab T

VII. Moonlighting House Officers ---------- Tab U

VIII. Role of the OSR and GSA Representatives in Monitoring Procedures of the National Intern and Resident Matching Program ---------- Tab V

IX. Annual Meeting Agenda Items ---------- Tab W

X. Report of the AAMC Committee on Financing Medical Education (Sprague Committee) ---------- Tab X

INFORMATION ITEM

I. Expiring Legislation ---------- Tab YZ

NOON
JOINT COD - CAS
ADMINISTRATIVE BOARDS
LUNCHEON

DISCUSSION WITH THE NIH
DIRECTOR - ROBERT STONE, M.D.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

March 15, 1973
9:00 A. M. - 4:00 P. M.
Conference Room
AAMC Headquarters

Present:

(Board Members)
J. Robert Buchanan, M. D.
Ralph Cazort, M. D.
Clifford G. Grulee, M. D.
Andrew Hunt, M. D.
William Maloney, M. D.
William Mayer, M. D.
Sherman M. Mellinkoff, M. D.
Emanuel M. Papper, M. D.
Robert S. Stone, M. D.
Robert L. Van Citters, M. D.

(Staff)
John A. D. Cooper, M. D.*
Paul Jolly, Ph. D.*
Amber Jones
Joseph Keyes
James R. Schofield, M. D.
August G. Swanson, M. D.*
Emanuel Suter, M. D.*
Bart Waldman
Marjorie P. Wilson, M. D.

(Guests)
Charles Sprague, M. D.*
Kevin Soden*

I. Call to Order

Dr. Mellinkoff, Chairman, called the meeting to order shortly after 9:00 A. M. The first order of business was the presentation of a photographic portrait of the University of Washington to the Association of American Medical Colleges by Dr. Van Citters.

II. Minutes of the Previous Meeting

The minutes of the December 14, 1972 meeting of the Council of Deans Administrative Board were approved as circulated in the Agenda Book.

III. Chairman's Remarks

Dr. Mellinkoff thanked the members of the Admistrative Board and the staff for their assistance in developing the program and carrying out the meeting in San Antonio.

IV. Follow-Up on COD Spring Meeting, 1973; Preliminary Planning for COD Spring Meeting, 1974

The Board began their discussion of this agenda item with a critique of the San Antonio meeting. There appeared to be a consensus that while the program itself may have met the standards set by the Phoenix meeting, the meeting as a whole compared

*Present for only a portion of the meeting

unfavorably with the Phoenix experience. The setting was identitied as the key difference. The Phoenix setting provided a less distracting environment which proved more conducive to informal interchange among the deans. The Board agreed that the primary criteria in selecting the 1974 meeting site should be the retreat atmosphere such as was created at the Phoenix Biltmore, because much of what is most valuable about the Spring Meetings occurs when the deans have more opportunity for informal exchange. There was substantial sentiment for returning to the Arizona Biltmore, or to some nearby Phoenix facility of a similar caliber such as the Camelback Inn or the Wigwam.

One view of the Council of Deans meetings in general, and this meeting in particular, was that there seemed to be an excessive preoccupation with the federal establishment and the problems created by the medical centers entangling relationships with federal agencies. It was suggested that there is a need to generate other approaches to dealing with medical center financial and programatic problems. Dr. Wilson related several informal discussions amongst the staff and with members of the Administrative Board relating to the use of the Delphi technique to accomplish just such an objective. That is, to stimulate from among the deans an expression of views regarding issues and problems that medical centers will face in the future because of changing political and technological environment and exploring potential approaches to the solution of some of the problems identified. Because of the substantial lead time required to develop and process the survey instruments and to accomplish the necessary iterations, it was impossible to use the Delphi approach appropriately in the time allowed. Consequently, it was decided to familiarize the deans with the technique by means of a brief introduction in Dr. Stone's remarks as moderator of the first session, and to distribute an example of a study done utilizing this technique by Smith, Klein, and French Laboratories on the Future of Medicine.

Noting that some fifteen to thirty percent of those attending the San Antonio meeting were attending a COD meeting for the first time, one Board member suggested that it would be appropriate to provide background material for new deans on the organization of the Association and its various activities. Dr. Grulee who had spent several days earlier in the week visiting the Association's offices discussed briefly the staff efforts underway to provide such material to every new dean as he assumes office. The staff is in the process of developing a packet of orientation material to be distributed to each new dean. In addition, the staff of the Department of Institutional Development has arranged for several pilot visits to Washington for orientation briefings with appropriate AAMC offices, and meetings with federal officials heading programs in the health and education fields. These visits have proven very useful according to the deans which have thus far participated, and plans are underway to expand this effort to make such an opportunity available to interested deans on a continuing basis. Finally, and relating

to the briefing visit effort, is the development of a document resource center and study facility which will contain major works on academic medical center organization, monographs on modern management techniques, and bibliographies of current documents and periodicals dealing with organization, management, and governance, as well as such issues as affirmative action plans, faculty unionization, and tenure. One Board member suggests that this effort and the Management Advancement Program Seminars would appropriately be supplemented by scheduling learning workshops for deans and their designated staff at the AAMC Annual Meeting. This might involve the scheduling of two or three workshops for one afternoon on such topics as, "Strategic Planning" or "Management Information Systems", for which people might register in advance.

The Board then proceeded to take up the issue of the appropriate formulation of the resolutions adopted by the Council of Deans at the San Antonio meeting and the determination of the appropriate follow-up action. The Board approved the formulation of the first resolution as follows:

> *"The Council of Deans recommends that the Executive Council direct the revision and expansion of the paper entitled, 'Medical Education, the Institution, Characteristics and Program - A Background Paper', to include a discussion of the issues presented and the development of a potential long-range strategy for approaching their solution; such a paper to take the form of a 'green paper' for discussion and review by the Executive Council, the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals and ultimate adoption by the AAMC Assembly."*

In considering the issues as formulated in the yellow book, it became apparent that what is being asked is an enormous undertaking. Estimates of the time required in order to address the issues adequately ranged from a year or two to something in the vicinity of ten years, depending upon the scope of the undertaking, the staff devoted to the effort, and the depth of the study and inquiry.

While the issues formulated each had substantial bearing on the future of medical education, there was some concern that the AAMC may well be an inappropriate agency to undertake such a study. Also, there is a very real limit to the time which either the Association staff or the constituents can devote to such an effort. On the other hand, the undeniable short-term political and economic interest of the medical centers may preclude the AAMC from undertaking the kind of disinterested study of the future of medical education, medical services, and biomedical research in the context of the larger public good which is really envisioned.

A somewhat different view of the problem was expressed by one Board member who asserted that the Association should be less concerned with political issues directed specifically to the needs of medical centers and speak out more forcibly on the urgent health-related social issues facing the country. In this view, the Association should address the health issues stirring great controversy- - - abortion in the current context, and hunger in America which is viewed as inevitably coming to the fore in the near future. There was no substantial concensus developed around this perspective.

Noting the unanimity of the deans favoring the resolution, the Board interpreted this expression of the deans as an overwhelming sentiment in favor of the Association stimulating a massive effort by some appropriate body to assist this nation to come to grips with the kind of issues raised in the yellow background paper. One suggested approach was to solicit the interest of a foundation to finance adequately a working group organized under a distinguished person and supported with an adequate staff. Such a study ideally should be unlinked from the routine processes and day to day organizational interests of this Association or any other. One view was that this could be accomplished by a study done under the auspices of the AAMC. The National Board of Medical Examiners' Goals and Priorities Committee was cited as one model for such an undertaking. In that effort, the Committee kept the Board informed of its activities but there was no requirement for interim clearances of the recommendations prior to the Committee's final report. On the other hand, that process involved a great deal more than the out-put of a full-time working staff. Instead, it required a substantial commitment of time and effort with many distinguished persons deeply involved in the medical education process.

At this point, the discussion was summarized as involving three different perspectives:

1) The view that there is no need for such a study, that the evidence is available for those who wish to see it and all that is needed is to engage the Council of Deans in a discussion directed toward public statements on pressing social issues.

2) The view that the action of the Council of Deans at the San Antonio meeting is an important one to address but that a great deal more Administrative Board time must be devoted to a consideration of how it should be implemented than was available at this meeting.

3) The view that there is a procedure which could be decided upon at this point, i. e., that the Executive Council be requested to direct the staff to undertake a study supported by financing solicited from a major interested foundation.

With the discussion thus summarized, it was suggested that the following approach be adopted:

That the principal agenda item of the June Administrative Board Meeting be a further discussion of the implementation of the COD resolution; that in the intervening period, the staff be requested to solicit the interest of foundations in supporting a strategic planning effort such as would necessarily be involved; and that in the interim the AAMC staff develop a discussion paper laying out alternative approaches to the implementation of the resolution for discussion and action at the June meeting.

ACTION: On motion, seconded and carried, the Administrative Board voted to report the action of the Council of Deans in San Antonio to the Executive Council with a request that it defer implementation of the COD recommendation pending a plan for implementation submitted by the Administrative Board of the Council of Deans subsequent to its June 21, 1973 meeting.

The Chairman directed that the record show he voted in opposition to the motion.

There was some further discussion subsequent to the adoption of the motion involving a further specification of the proposal to be discussed with the foundations. It was suggested that there needs to be a clear distinction between the continuing work and mission of the Association and the project being opposed. One Board member was troubled by lack of clarity and the focus of the preceding discussion. In his view, there were a series of issues appropriate for consideration by the AAMC as a national organization representing the medical centers. There was a second set of issues appropriate for consideration by a consortium of national organizations (including the Association) addressing matters of broader scope and significance. There was a third set of issues which needed to be addressed at each individual medical school relating to its own planning for the future.

It became apparent that further deliniation of a specific proposal to be made to any foundation must await further consideration of the Board at the June meeting. On the other hand, the Board expressed its desire that foundations be contacted and that prior to the June meeting, substantial planning be done. It was emphasized that the Board was disappointed with the failure to implement what it considered a similar proposal resulting from the Phoenix meeting, that is that the Association stimulate a major undertaking on a national but supraorganizational level dealing with the substantial issues facing medical education and medical care in this country.

In other follow-up action, the Administrative Board approved the formulation of the second motion adopted at the Spring Meeting in San Antonio as follows:

"The Council of Deans recommends that the Executive Council develop, for public release in an appropriate manner, a statement of the Association's support of the present role and contribution of the Veterans Administration in the support of medical education and acknowledging the appreciation of the Association for the effectiveness of the present leadership

enhancing VA medical school relationships."*

V. The OSR: Where It Is, Where It's Going

The Board heard a report from the current Chairman of the Organization of Student Representatives, Mr. Kevin Soden. Mr. Soden indicated that the major emphasis of the OSR activities this year has been to improve communications both among the OSR members and between the OSR and other student organizations. The internal communications are being handled by the following devices:

A. The development of a newsletter from the OSR Chairman to OSR members distributed on an intermittent, perhaps monthly, basis;

B. Participation in regional meetings with the Group on Student Affairs;

C. Reformat of the OSR Annual Meeting: This year a series of task-oriented small-group discussions will be held. In addition, the OSR is encouraging its members to develop information packets on the AAMC at each school containing all of the information distributed to the membership from its chairman and the AAMC staff. Hopefully, this device will provide some method of maintaining a higher level of understanding of the AAMC at each school and assist in providing a smoother transition for new OSR members.

In order to improve communications with other student medical groups, the OSR is developing a liaison with the SAMA and the SNMA. Mr. Soden is attending meetings of these organizations.

Items taken up at the regional meetins include developments in the following areas:

A. Three-year schools;

B. The role of National Board Examination, Part I;

C. The potential for a medical school admissions matching program;

D. Primary care programs;

E. The potential for a senior electives catalogue; and

F. A survey of students who participated in projects in international health.

*This action of the Council of Deans was reported to the Executive Council on March 16, 1973, but no action was taken by that body. Follow-up action took the form of letters from Dr. Mellinkoff as Chairman of the Council of Deans to President Nixon, the Chairmen of the House and Senate Veterans Committee, and the Administrator of the Veterans Administration. A copy of that letter is attached to these minutes (Attachment I).

A major interest of the OSR is in the development of a procedure for the surveillance of NIRMP with the object of bringing violations of the established procedure to the attention of deans and others who would be of potential influence in rectifying violations.

The matter of financial realities was discussed. Mr. Soden indicated that a number of the students were concerned that their participation in the OSR is severely limited by constraints on travel funds. Board members explained that the schools are under severe financial constraints at the present time and that travel funds are hard to come by not only for the students but for faculty members and others within the institution as well. The Board explained that it would be inappropriate for it to attempt to exert any pressure on the deans to make funding commitments to the OSR in the current climate.

The students were also chafing a bit under the organizational structure which places the OSR in a subsidiary role to the Council of Deans. It was explained that the students are a second institutional representative to the Association and that all institutional representatives needed some organizational relationship within the Association to distinguish them from representatives of other groups within the constituency which are formed into Councils. In other words, there are legal as well as political reasons for the existence of the current structure.

VI. The Annual Meeting Program

The Administrative Board agenda book contained a description of the general outline of the 1973 AAMC Annual Meeting which will be held November 4 - 8 in Washington, D. C. This represents a change in format from the weekend meeting to one which will begin on Sunday and continue through Thursday. The theme of this year's Annual Meeting is "Preparation and Role of the Physician: Comparative Approaches". The Plenary Sessions will be devoted to examining the changing role of the physician in the United States and abroad. Two or three international speakers will discuss this phenomenon from the perspective of their countries, and the remaining speakers will relate these experiences to the present and future American physician. The Allen Gregg lecture will provide a global summation of the changing role of the physician and how the medical schools might better prepare students to meet the new challenges.

Since the Annual Meeting has grown to well over three thousand participants, it has become an increasingly attractive forum for political speeches on health. With the meeting location in Washington, D. C., it would be difficult and politically unwise to attempt to exclude completely Congressional administrative spokesmen. Moreover, the presentations of the political leaders seems to be the most favorably discussed part of the meeting.

The Association has asked President Nixon to address our meeting. Should the President prove unwilling, the Secretary of HEW will be asked in his place. In addition, Congressman Wilbur Mills and Senator Russell Long have been asked to speak.

Sunday will serve as the arrival day for most participants, and plenary sessions will be held on Monday and Tuesday mornings.

Business meetings of the Councils will be held on Monday afternoon and the Assembly meeting on Tuesday afternoon. Wednesday morning will be reserved for a program of the Councils. Sunday afternoon, Wednesday afternoon, and all day Thursday will be open for committee meetings and meetings of outside groups (including Academic Society meetings). Thus, the schematic of the Annual Meeting Program would appear as follows:

	S4	M5	T6	W7	Th8
AM		Plenary	Plenary	Council Program	Misc.
PM	Misc. / OSR	Council Business	Assembly Minority	Misc.	Misc.

Indications are that items needing specific COD action may be few and subject to rather expeditious handling. Thus, it may be possible to devote a significant portion of the Business meeting to the presentation and discussion of the reports of the Association activities of major importance to deans, for example, developments in the area of accreditation; the activities of the Coordinating Council on Medical Education; the Liaison Committee on Graduate Medical Education, etc.; and the efforts of the Management Programs Coordinating Committee, the Management Advancement Program, and the Management Systems Development Program.

Several suggestions had been received regarding possible COD programs. These include:

1. A program devoted to medical school information system requirements,

2. A program devoted to an exploration of the administrative arrangements and quality control considerations relating to satelite medical education programs,

3. Joint sponsorship of a program being developed by the AAMC group on Medical Education and the Group on Student Affairs devoted to an exploration of the role of internal and external assessment programs in the selection and promotion of students,

As currently planned, this program would run for a day and consist of several sessions focusing on the AAMC medical college admissions assessment program, the role of internal faculty assessment of students, and the role of external assessment programs including a consideration of the report of the National Board of Medical Examiners Goals and Priorities Committee.

4. A program devoted to the examination of the issues involved in Professional Services Review Organizations (PSRO's), and

5. The role of the academic medical center in the development of educational programs for the teaching of primary care.

After extended discussion, the Board agreed to join the Group on Medical Education and the Group on Student Affairs in co-sponsorship of the program on medical student assessment. Other subject matter such as the PSRO's might be covered either in the Business Meeting on Monday afternoon or on Sunday afternoon or evening.

VII. Admissions Problems, Follow-Up

1. Visitation Meeting

Dr. Grulee reported on the February 16, 1973 conference on Visitations to Undergraduate Colleges Concerning Health Professions Admissions Problems held under the sponsorship of the AAMC. In summary, the participants at the conference believe that steps should be taken to communicate as straightforwardly as possible with applicants to health professions schools concerning admissions problems, but there was no enthusiasm for direct campus visitations to accomplish this goal. From the comments and suggestions made at the conference, two actions seemed to be called for: 1) a detailed brochure including current statistics on the "demography" of application and admission to medical and perhaps dental school should be provided to health professions advisors as a supplement to THE ADVISOR. The advisors could then request copies as needed for distribution to their students. 2) a meeting of representatives of the health profession school staffs and associations of undergraduate colleges and universities should be convened to consider the problems created by excessive of applicants for both colleges and health professions schools. General concern of such a conference would be to consider ways of reducing forestalling such tension.

2. Matching Plan Meeting

Dr. Grulee also reported on an ad hoc advisory panel which was convened on March 12, 1972 to review a feasibility study for medical student admissions matching program. The panel concluded that while a matching program was technically feasible as a means of handling medical student admissions, an alternative approach to dealing with the problems being encountered in the admissions process would be substantially more desireable, at least in the short run. The panel endorsed a proposed four-stage plan to help alleviate the admissions crisis (Attach. II). The key points of the plan are summarized as follows:

1) Stage 1 (Information Dissemination) could conceivably reduce the potential pool from 40,000 to perhaps 35,000 and might well lower the average number of applications per applicant from the current 7 to perhaps 6. This above would result in an overall reduction of 70,000 applications. The publicizing of more specific information about the characteristics of accepted students has long been urged by applicants and by premedical advisors and many schools have started doing this, particularly those participating in AMCAS.

2) Stage 2 (Early Decision Plan) could eliminate approximately 45,000 applications if the proposed maximum target of 50% of the 15,000 places were filled via this plan. It should be

noted that under this proposal, applicants would have 2 1/2 months to apply, advisors would have until October 15 to submit their evaluations and the medical schools would have until November 15 to complete their screening of EDP applicants. Indicentally, non-EDP applications would also be submitted anytime after July 1, but they would be clearly marked so the schools could process them at their leisure.

The rationale for a significantly expanded EDP is as follows:

a) The approximately 50% of entering students who are so outstanding that they have an excellent chance of admission to their first choice school could decide on this choice a full year before matriculation.

b) Without an expanded EDP, these students would probably apply to an average of six additional schools to assure themselves admission.

c) The added applications are largely a waste of time, effort and money for the six schools and for the exceptional applicant. This time, effort and money could better be spend by the schools in evaluating applicants requiring more thorough consideration.

3) Stage 3 (Uniform Acceptance Date) would allow any EDP applicant rejected on November 15 a month to file additional applications. It would also allow the advisors until January 15 to submit their evaluations on these and on all non-EDP candidates. Even more importantly, the uniform date would enable the medical school to consider its remaining pool as a whole and would permit the applicant to receive and consider all of his offers simultaneously. He would also have a full month (rather than the current two weeks) to compare schools on financial and other grounds and to reach a firm decision, thus greatly reducing the current problem of widespread "musical chairs".

4) Stage 4 (Rolling Admissions) would enable schools to complete balancing their classes. Since only a proposed 10% of the class would be filled after February 15, admissions staffs should have a much less demanding Spring work schedule than is now the case. This in turn, should help prepare them for the slightly heavier Summer and early Fall work schedule that could result from filling up to 50% of the class via the Early Decision Plan.

5) Rejection notices would continue to be mailed as promptly as possible after all of the rejectee's pertinent admissions credentials have been received and evaluated by the medical school. This will allow the rejected applicant to start making plans as early as possible.

The Administrative Board was impressed with the four-stage plan and endorsed it in principle. The Board also endorsed the proposed procedure for consideration and adoption of the plan as follows:

1) Approval in principle of the proposed four-stage plan at the Spring, 1973 regional meetings of the GSA, OSR and AAHP.

2) Official approval of the four-stage plan (slightly modified if necessary) at the Fall, 1973 national meetings of the GSA, OSR and COD.

3) Implementation of the national plan starting in November, 1973 to help alleviate the admissions crisis for the 1975-76 entering class.

4) Implementation of plan on a local or regional level starting in the Spring of 1973, if desired, to help simplify the application process for the 1974-75 entering class.

VIII. Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibilities for Graduate Medical Education

After extensive discussion, this document was given "Provisional Approval in Principle". The contingency related to the Board's strong recommendation to the staff that several changes in the language would be advisable and necessary for full endorsement by the Board. These changes should modify the emphasis of the document in two respects:

1. It should be made quite clear, especially in the foreward, that the document is a statement of an ideal toward which the efforts of the institution might be directed. There should be no indication that the document was in any way binding on any institution but rather an internal document for the use of faculties seeking to implement the previously adopted policy statement.

2. There should be some further recognition in the document that faculties are currently constrained from carrying out the recommended courses of action by restrictions placed on graduate programs by specialty boards. Some exhortative statements directed to the Boards would be considered useful by the Administrative Board.

IX. Report of the Ad Hoc Committee on Continuing Education

The Board declined to endorse the report of the Committee as written. Instead, it endorsed five of the nine recommendations contained in the report as appropriate statements of AAMC policy and recommended their adoption by the Executive Council.

The recommendations endorsed by the Administrative Board were the following:

1. *The medical faculty has a responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to demonstrate that they are competent to deliver care to patients throughout their professional lives.*

2. *Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to insure the deficiencies in meeting these criteria are brought to the attention of physicians who*

are performing below the expected norm.

3. *Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected to the systems developed for accomplishing recommendation number two. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.*

4. *Evaluation of the effect of educational programs should be planned from their first inception. Evaluation should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day to day practice. Dependence upon subjective evaluation of participants and/or cognitive evaluation may be spurious and misleading.*

5. *Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.*

The remaining recommendations and the text of the committee's report were considered by the Board to contain comments which were needlessly offensive to many who are currently engaged in continuing education programs. In addition, the remaining recommendations suggested approaches which were viewed by the Board as untried and unproven , or at least so controversial that they should not at this point be adopted as AAMC policy. Thus, the Board recommended that the Executive Council return the report to the committee for the development of a new paper which would expand upon the statements of policy adopted by the Executive Council, exploring their implications and developing a proposed definition of the appropriate role of the AAMC and its constituents in continuing education. The Board further recommended that the Association increase its communication with a number of individuals prominent in the field of continuing education to obtain their input on an appropriate role of the Association in their field of endeavor.

X. The AAMC Position Regarding Legislative Extension of the RMP-CHP Programs

The Agenda Book contained a proposed AAMC position on this matter. The Board took the position that they had insufficient information available to them to enable them to take any position to endorse, to modify or even to comment upon the proposal.

XI. WHO Study on International Migration of Health Manpower

Dr. Emanuel Suter, Director of the Division of International Medical Education, recommended that the Board encourage AAMC endorsement of a proposed study by the World Health Organization. Dr. Suter pointed out that international migration of health manpower, particularly of physicians and nurses, has assumed major proportion and has important implications for donor and recipient countries. Background data on the movement of these professionals in their motivating factors, and the consequences

of their movement for health care in affected countries are not available. In order to provide basic information necessary for an assessment of the situation in different countries, and for gaining an understanding of its dynamism, World Health Assembly of 1972 requested the Director-General of WHO to undertake a comprehensive study. Plans and instruments for the study have been developed in Geneva under the direction of Dr. Alfonso Mejia.

The study has the following objectives:

1. To determine dimensions and patterns of migration of physicians and nurses;

2. To identify characteristics, motivation, satisfaction and dissatisfaction of those who migrate;

3. To determine economic and non-economic factors which cause physicians and nurses to migrate;

4. To identify in the affected countries the economic and non-economic effects of migration; and

5. To postulate alternative strategies for monitoring and intervening if necessary in the process of migration.

In view of the importance of the issue of the foreign medical graduate in the United States and of the expectation that this study will provide valuable data, the Board recommended that the AAMC endorse the proposed WHO study and offer its participation with a proviso, that it not incur any financial responsibility unless funds could be obtained from outside sources.

XI. International Consortium for the Advancement of Family Health

The Agency for International Development, through its Bureau of Population and Humanitarian Assistance, is proposing to develop a program aimed at worldwide improvement of the health of women as an effective mechanism for raising the standard of health of the family and particularly the child. The proposed project consists of the following three component programs:

1. To develop an international system for continuing education of ob-gyn leaders in medical schools and in practice in the area of reproductive biology, demography, maternal and child health, and fertility control;

2. To initiate a network of health clinics for women by a trained specialist; and

3. To establish a supply system for equipment and materials used in these clinics.

In order to develop a program of continuing education which can reach ob-gyn faculties at their request in countries accessible to AID in which may make best application of modern educational technology, an international consortium is proposed to take responsibility for all of these phases of the project.

The Agency for Internal Development is turning to the AAMC for assistance in establishing the international consortium for the project. Specifically, the AAMC has been requested to assume the responsibility for the initiation and establishment of the consortium which will then receive five years of guaranteed support for the implementation of the project. The contract with the AAMC will be limited to twelve to eighteen months depending upon the progress of the initial negotiations.

The Administrative Board recommended that the Executive Council endorse a proposal that the AAMC authorize negotiations of the contract to develop the international consortium for the advancement of family health.

XII. The meeting was adjourned at 3:50 P. M.

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

OFFICE OF THE DEAN
SCHOOL OF MEDICINE
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

May 9, 1973

MAY 14 1973

PRESIDENT RICHARD M. NIXON
The White House
Washington, D.C.

Dear Mr. President:

In my capacity of Chairman of the Council of Deans of the Association of American Medical Colleges, it is my pleasure to relate to you a recent action of that group.

By unanimous vote, the Council, made up of the deans of the nation's 114 medical colleges, acknowledged its appreciation for the contribution of the Veterans Administration in the support of medical education.

The Deans, solicitous of the well-being of the current role of that agency in the education of our future physicians, emphasized their continuing and whole-hearted support for the system of mutually supportive relationships between the medical schools and the Veterans Administration hospitals developed over a proud history of shared concern for our nation's health. In particular, they expressed their appreciation for the effective leadership within the Veterans Administration which has contributed so substantially to the enhancement of these relationships.

Sincerely,

SHERMAN M. MELLINKOFF, M.D.
Dean, UCLA School of Medicine
Chairman, Council of Deans,
Association of American Medical
Colleges

SMM:jcm
Identical letters were sent to:

Senator Alan Cranston, Chairman, Committee on Veterans Affairs for the Sen.
Congressman William J. Bryan Dorn, Chairman, Comm. on Vet. Aff. for the Hse
Mr. Donald E. Johnson, Administrator, Veterans Administration

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Draft of Proposed National Four-Stage Plan to Help Alleviate the Admissions Crisis for the 1975-76 Entering Class#

Stage	Key Features of Plan	Proposed % of Places to be Filled	Advantages of Each Stage (assuming potential 40,000 applicants for 15,000 places)	Proposed Dates			
1 - Information dissemination to applicants and advisors	Publicize widely (a) national facts such as only 1 in 50 out-of-state applicants are admitted to state schools and (b) local statistics about characteristics of last entering class at each medical school	—	1) Should help discourage some poorly qualified individuals (5,000?) from applying to any medical school at all. 2) Should help discourage others from applying to specific schools (1 each?) where their chances of admission are essentially zero. 3) The above would eliminate 70,000 applications.	Admissions Book Deadline - 11/73 AMCAS Participation Deadline - 12/73 AMCAS Booklet Deadline - 2/74 The Advisor, Datagrams and news releases - starting immediately Medical School Catalogs and Admissions Publications - 1973 on Future use of MCAAP to help applicants decide whether and where to apply - 1974 on			
2 - Early Decision Plan (EDP)*	Applicant applies to only 1 school by specified date (e.g. 9/15) which he agrees to attend if accepted by given date (e.g. 11/15)	up to 50%	1) Would eliminate approximately 45,000 applications (7,500 x 6) or an average of about 400 per school. 2) Should enable schools to enroll more of their first-choice applicants.	Application Dates	Premedical Evals. Due	Applicants Notified	Applicants Reply by
				7/1 - 9/15	10/15	11/15	12/1
3 - Uniform Acceptance Date	No offers other than EDP would be made until specified date (e.g. 2/15)	40% or more	1) Would allow schools to consider remainder of applicant pool as a whole, with more equity for applicants and a better chance to obtain a balanced class. 2) Would eliminate "musical chairs" for all but a maximum of 10% of acceptees. 3) Month to reply to simultaneous offers allows applicant time to consider financial and other aspects of decision.	7/1 - 12/15	1/15	2/15	3/15
4 - Rolling Admissions	Offers may be made any time following specified date (e.g. 2/16)	10%	1) Would allow schools to balance out class as regards women, minority group members, out-of-state residents, etc.	7/1 - 12/15	1/15	2/16 to Start of Classes	2 Weeks After Receipt of Offer

*Possibly rename as "Single Application Stage."
#Could also be instituted at the local or regional levels for 1974-75 entering class if desired but would require special publications.

N.B. Rejection notices should be mailed as soon as possible after the rejectee's admissions credentials have been received and evaluated by the medical school.

DGJ/sg 3/15/73 W#8335R/1

COD Minutes
Attachment II

Further Consideration of the Council of Deans "Green Paper" Resolution

The following paper has been prepared by Dr. Marjorie P. Wilson, with appropriate technical advise on the strategic planning process, to assist the Administrative Board in its deliberations regarding appropriate follow-up of the COD San Antonio Resolution. This matter is the major item for Board consideration as per its decision of March 15, 1973.

A Discussion Paper for the COD Administrative Board
The COD Resolution - San Antonio - 1973

This document is a discussion directed to members of the Administrative Board of the Council of Deans and intended to generate members' reaction and response prior to their June meeting.

At the conclusion of its most recent meeting (San Antonio), the Council of Deans passed a resolution urging the development by AAMC of a strategic planning "green paper" based upon the January, 1973 background paper titled Medical Education: The Institutions, Characteristics and Programs.* That background paper includes identification of a number of issues or questions. The cumulative effect of answering those questions could be highly influential in determining the course of medical education in this country for some time into the future.

At its most recent meeting (March, 1973), the Administrative Board considered the resolution passed in San Antonio and elected to delay its transmittal to the Executive Council. The Administrative Board agreed that it should have the benefit of an analysis of the intent and possible consequences which could arise from the Council of Deans' resolution. It was agreed that there would be discussion which might occupy all of the time of the June meeting and which would serve to clarify for the Administrative Board just what it would and should be doing when it sent the COD resolution up to the Executive Council.

In the present paper, a systematic action plan is discussed which would have as its outcome transmittal of the COD resolution from the Administrative Board, accompanied by an outline of a possible plan of action.

*Referred to in this paper as the YELLOW BOOK.

Presented with a proposal for action the Executive Council might adopt one or a combination of several alternatives:

1. Subject to appropriate protocol, the proposal (all or in part) would be considered by the three Councils and then by the Assembly.
2. React to and revise the working draft and reconsider it at its own next meeting having the benefit of, by then, similar consideration by the Administrative Boards of the three Councils.
3. Adopt some other possibly delaying action. (Appoint a committee.)

I. Turning the Issues Identified in the Working Paper Into a Series of Strategic Action Plans for AAMC

The issues have been extracted from the January, 1973 background paper and are Appendix A, attached. The issues are in four categories: Educational Activity, Biomedical Research, Health Services, and The Financing of Academic Health Centers. The resolution of these issues is extremely important to AAMC as an organization and to its constituent groups. Strategic planning crept into the discussion in San Antonio obviously as a result of discussion of this concept at recent seminars. However, we need to be clear on the meaning of strategic planning technically so that the term is not misused. It is not simply jargon, but has a special meaning. An explanation and illustration follow.

As a first essential step in developing a strategic plan for anything, AAMC as an organization must be clear about its position or stance with regard to the issue. In the context of the YELLOW BOOK ISSUES, that is to say, for each of these issues, how would AAMC want to have the question answered in order to be most beneficial to its constituent groups? The consequence of the statement just made is that AAMC staff and/or elected body must

examine each one of the issues and then adopt an explicit position on that issue as a first step.

After a position is adopted on each issue, a set of goals and objectives should be derived, the accomplishment of which would lead to the resolution of the question in the direction which AAMC believes is in the best interest of its constituent groups. The strategic plan is the action plan which AAMC as an organization intends to pursue in order to gain accomplishment of the goals and objectives which it is believed will bring about the desired outcome of the issue question.

In the course of developing the strategic plan needed to accomplish each set of goals and objectives some policy statement might need to be adopted as the decision rules which would be utilized in the implementation of the strategic plan. The strategic plan will include a feedback or control loop which will trigger recurring comparisons between progress towards attainment of the goals and objectives and the actual goals and objectives as they were stated at the beginning of implementation of the strategic plan. Each time that the comparison is made as a result of the operation of the feedback loop, the strategic plan itself might be revised, policy statements might be revised, or goals and objectives might be revised.

Allocation of resources is made at several different planning levels. At the highest level there would be an allocation of some resources to the accomplishment of each one of the issues in a favorable direction based on perceived relative importance of the issues. Within each strategic plan resulting from the setting of goals and objectives for each issue there is further lower planning level allocation of resources.

It should be recognized that this entire systematic approach can be applied at each decision-making level in the total organization depending on the level of aggregation of problems addressed. Therefore, the Administrative Board might also want to give some attention to what might be in a sense called "grand strategy" for AAMC although this is more appropriate business for the Executive Council. In looking at AAMC as an organization from that highly aggregated level one of a large number of issues facing the organization could be stated as "what should the organization do with the January, 1973 working paper?" This was stated above as one alternative viewpoint for the Executive Council relative to the COD resolution.

Although not aware of the larger frame of reference at the time when it took its action, the Council of Deans in San Antonio was essentially adopting a position relative to this particular issue, namely that the Executive Council should utilize the working paper to somehow advance the purposes of AAMC and thereby its constituency. For each issue a position and strategic plan is needed. It is important to recognize that each time a position is adopted by any body of the AAMC, that position itself should be reassessed on some cyclical basis. Depending on the liability of the issue, re-examination of the body's position might be considered monthly, quarterly, yearly or perhaps every five years.

In summary then if we really mean systematic strategic planning applied to these issues the approach is as follows:

1. adopt a position
2. set goals and objectives
3. state decision rules
4. allocate resources
5. feedback

II. A Hypothetical Illustration of Action Following The Course Described Above

In an attempt to clarify the process described above, a hypothetical course of action is now described. The substantive response in this example is not advocated, only the process.

The first issue statement in the background paper is: "should national policy continue to support further expansion of medical education?"

Step Number One. After assembling an appropriate data base, supporting documents, and rational arguments staff together with members from the constituent groups develops a working paper which finally results in Assembly action to wit: "it is the position of AAMC that the federal government should directly support medical education in the United States by the appropriation of money which will be given directly to the institutions and by other legislative actions which from time to time are believed to further the advancement of medical education. It is further the position of AAMC that the current capacity of the medical education system of this country should be increased each year in a step-wise fashion such that the percentage of students enrolled in schools working for the M. D. degree will be in a relatively constant ratio to the total population of the country. It is also the position of AAMC that the cost of this yearly increment should be partially born by funds derived from federally controlled sources."

Note that the term "national policy" has been eliminated from the position statements adopted by AAMC. Technically no body currently exists with authority to enunciate and implement "national policy" on this issue. At such time as there might

be legally established a body which actually has the power to set "national policy" relative to medical education, the AAMC Assembly could adopt the position that: "the National Health Education Policy Board should adopt as policy for the federal government (that is as a 'decision-making rule' for the federal government's agencies) 'do everything that you can to further the expansion of medical education in the United States'."

Step Number Two. A list is prepared of goals and objectives the accomplishment of which would advance a particular position advocated by AAMC. In this hypothetical example, one such objective might be "to have the 94th Congress pass a law which authorizes the expenditure of x millions of dollars during each of the next three years for the support of increases in enrollment in the nation's medical schools". Note several things about this objective. Attainment of this objective alone would not in and of itself produce the desired outcome fulfilling the position adopted by AAMC. A number of other objectives also would have to be attained. These would include, for example, (incompletely) the appropriation of money and the spending of money by the executive branch. Note also about this first example of an objective that there is an event or a behavior which we can say objectively did or did not happen. That is, we could say unequivocally and with agreement by all observers that it did happen, did not happen or happened partially, We would say that it happened partially if instead of the authorization of x millions of dollars, the authorization was for x minus z millions of dollars.

Step Number Three. A strategic plan is now adopted which

will lead to the accomplishment of each of the objectives listed in step number two. For example, a plan which AAMC would follow leading to the attainment of the objective given as an example in step number two is, (incompletely) as follows:

1.1 Write a letter to each congressman saying that this authorization must be made.

1.2 Write a letter to the President asking him to support the bill.

1.3 Take out a full-page ad in the New York Times asking people to write to their congressmen supporting the bill.

1.4 Demonstrate in front of the White House.

Step Number Four. The strategic plan would include assignment of resources including designation of a responsible person to see that the plan is carried out. The plan would also include necessary policy statements or decision rules which that responsible person would have reference to for guidance in carrying out the strategic plan. An example of such a policy could be: "make sure that the dean of the state medical school in every instance has seen and approved the letter before it goes to the congressmen representing his state". That is a policy statement or decision rule against which the responsible person must measure each proposed episode of letter writing.

Step Number Five. Provide a feedback loop. For example, the responsible person assigned the execution of the strategic plan shall report monthly to the President of AAMC on the progress made in the execution of the strategic plan. The President and the responsible person will then review that progress and they might then decide to change the strategic plan.

Note that the allocation of resources within the framework

of attainment of the set of goals and objectives which one is trying to reach is a subset of total budget-making. That is to say, budget-making also occurs at multiple planning levels depending on the aggregation of strategic planning with reference to the over-arching position regarding obtaining support for expansion of medical education. The AAMC might decide to allocate ten percent of its own total resources to furthering the particular position which it has adopted. However, because of matters such as joint cost, with which we are quite familiar, the disaggregation from budgetary allocations could be done to such a micro-level that it is counterproductive. Nevertheless, theoretically it would be possible to say out of the ten percent of total resources of the Association assigned to furthering such and such a position, ninety percent will be devoted to attainment of some specific sub-objective which is considered essential to the accomplishment of the next higher level position.

III. Preliminary Analysis and Comment on Issues Extracted from Working Paper

As a preliminary step in sharpening the focus on the issues and in categorizing these, the following comments on the issues are offered. Also the Administrative Board may want to ask itself the questions, "what does COD really mean by the resolution and what commitment does the Administrative Board have to action by AAMC on it?" Note that there might be some issues on which the Administrative Board would adopt a position, other issues on which the entire COD would adopt a position, different issues on which the Assembly would take a stand and still others on which the President and staff must react quickly, without formality. In choosing to deal with the issues in the background paper, AAMC

can be highly selective with regard to the effort and formality of strategic planning applied to each. This gross sorting could be done by the Executive Council and/or the President. Somewhere, of course, the organization should have the "grand strategy" explicated.

A "green paper" is a discussion paper which sets for a position for discussion. The "white paper" represents the final position which is adopted. Having just elaborated by illustration the meaning of strategic planning as applied to accomplishment of objectives which would relate to each of the "issues" in the YELLOW BOOK, one observes that as a first step, a position must be adopted on each of these issues. Perhaps there should be a "strategic plan" for developing a position on each of these issues, and then as outlined above, a plan for accomplishing the objectives underlining each position. In order to adopt a "position" on these issues, it would appear considerable work would have to be done to establish the recommended position. It appears that the important point the COD is making is its desire to carry these matters beyond the development and adoption of a position to a strategic plan for bringing it into effect, including the definition of clear cut objectives and a clear understanding of the necessary allocation of AAMC (or other) resources to the achievement of the objectives.

Again, a look at the "issues" themselves may be helpful. The issues in the YELLOW BOOK relate to four major categories:

Educational Activity
Biomedical Research
Health Services
The Financing of Academic Health Centers

A. EDUCATIONAL ACTIVITY ISSUES

The issues under Educational Activity are as follows:

1. Should national policy continue to support further expansion of medical education?
2. What should be the determinants of the rate and extent of any further expansion:
   ... Perceived health care needs?
   ... Volume of applicants?
   ... Diminishment of dependence on foreign medical graduates?
3. What should be the distribution of responsibility (public-private, Federal-non-Federal) for the resources required for any further expansion?
   ... In capital expenditure?
   ... In continued operating support?
   ... In assuring the availability of additional faculty?
4. How and by whom should acceptable qualitative levels of educational programs and performance be assured?
5. Should greater attention be given to national policy development for graduate clinical education, its financing and its role in the specialty and geographic distribution of physicians?

The first three of these are very much interrelated and could be restated as follows:

Should there be further expansion in the number of medical schools and/or enrollment? For what reasons? How should it be paid for?

It seems to this writer that the development of a position on these issues is a project in itself, although it need not be an elaborate undertaking. It could be done by a professional level person, with an aid for "leg work", and someone to type

the papers. The speed with which this type of work is accomplished depends on the style of the professional and the familiarity of the team with relevant previous work and history. The equally important question is by whom should the position be accepted - the Executive Council, the Assembly, the President, before the strategic plan for its accomplishment is laid out?

Issue four in this group is of interest to two sets of groups: 1) agencies subsidizing educational programs or licensing individuals, e. g., Federal and State governments, and 2) those representing the profession and concerned with internal standards, quality assurance, and taking a responsible position toward society, i. e., the schools, AAMC and AMA. One means by which the first of these groups is pursuing its interest is through a study on the use of accreditation as a mechanism for determining institutional eligibility for Federal funds sponsored by the Office of Education. The study, which will require a year or more to complete, is being conducted under the direction of Harold Orlans at the Brookings Institution. Orlans has at least two professionals working with him on it.

One means by which the AAMC seeks to secure some assurance as to the quality of educational programs is through its accreditation activities carried out in conjunction with the AMA through the LCME and with others through the LCGME and the Coordinating Council on Medical Education. The AAMC could well undertake to formalize its position on this matter. We have a position under which we operate now and in a sense we have a "strategic plan" for carrying out the objectives derivative of that position. Objectives are only partially spelled out, but there are some. Resources allocated to their achievement here include on a

regular basis one full-time professional, an administrative assistant, one secretary plus one third time of another professional. Additional input is made on an ad hoc basis of, at the most, one-half FTE professional and one-half FTE secretary. There is an operating position on "how and by whom" accreditation is done, and it is reiterated briefly on an ad hoc basis from time to time, but no carefully stated written position has been developed. It probably should be.

An important aspect of the accreditation work is the quality of its own procedures and process. Addressing this matter, the Secretary of the LCME last fall introduced the question of converting the present process to one of self-study by the institution. There is presently before the LCME Task Force on Accreditation Policy a discussion paper suggesting that the LCME develop a strategic plan for converting to a self-study process. On looking into this matter, there is some indication additional resources may be needed by the LCME for a year or two which, frankly, had not been in our original thinking.

Issue five in this group deals with graduate education and implies that attention at the national level should be directed at policy development re:

Specialty distribution of physicians
Geographic distribution of physicians
Financing of graduate education

The issue as stated does not indicate who should give attention to this so that would become part of the statement of an "AAMC position" on this subject. At the present time, AAMC has a Committee on Graduate Education and a Subcommittee on the Financing of Graduate Education which reports to the AAMC Committee on the Financing of Medical Education. Also, the Coordinating

Council on Medical Education and the Liaison Committee on Graduate Medical Education are beginning to include these questions on their agenda. Again applying the "strategic planning" concept - AAMC should develop a position on these issues, then set forth a plan for arriving at that outcome or altering the position and outcome, including the delineation of its resources being applied to this effort.

Some of the existing Committee's effort could be directed toward the achievement of the AAMC position. It might also be worthwhile for AAMC to have such a "going-in" position explicit as it becomes involved in discussion of these issues with other organizations - although this may not be essential. But these are the types of decisions which need to be consciously made.

Before moving on to comment on the other three sets of issues - Biomedical Research, Health Services, and Financing of Medical Education, consider where we are in handling the COD Resolution as a result of looking at the first set of issues on Educational Activity.

First of all, they represent a mixed bag. To establish AAMC positions, old information could be used, but some new information would have to be generated. Issues one, two, three and five are somewhat related, cover undergraduate and graduate education, speak to the number of physicians produced and in what specialties, how they should be distributed, what resources and facilities are needed to produce them and how those resources should be financed.

1. Are these issues of importance to AAMC and its constituency? Answer: *Yes.*

2. Should AAMC concern itself with these issues? Answer: *Yes. With the demise of the BHME and health professions*

> *assistance legislation due to expire in two years, the AAMC needs to worry about where it stands, what the needs are in relation to national resources, and how the AAMC best serves its constituency in this context. What the COD seems to be calling for is a strategic plan for doing this.*

The COD Administrative Board raised the question as to whether such studies could or should be undertaken within the present structure of the AAMC co-mingled with the on-going work. The suggestion was made (See minutes of March 15, 1973 meeting of the COD Administrative Board) that a special group be established under the direction of an experienced individual to undertake the necessary studies. In fact, staff was instructed to test the likelihood of foundation support for such a venture prior to the June meeting. Hopefully, the commentary which is being provided will illustrate why staff failed to respond to this request. First of all, a clearer statement of what was to be done is necessary before soliciting foundations even informally, and secondly, it appeared premature until the COD Administrative Board had an opportunity at the June meeting to formulate its recommendations more specifically and discuss them with the AAMC President.

There is, of course, some merit to the idea of a separate group either under the direction of the AAMC or advisory to the AAMC taking this on. The point was made that the decision as to the appropriate sponsor of the effort should be considered not only in the context of resource allocation. Of considerable significance is the question of whether AAMC can look at these matters of national priority objectively, and at the same time primarily serve the interests of the constituency, or to carry it a step further, serve the <u>vested</u> interests of its constituency.

To dispose for the moment of the Educational Activity issues, number four deals with quality of programs and is related but as was pointed out earlier, opens up an additional group of concerns.

NOTE: In order to save space and the time of typists, would the reader please turn to the Appendix and review the issues listed under the additional three rubrics as we proceed to comment on each.

B. BIOMEDICAL RESEARCH

The issues under Biomedical Research neatly summarize the questions basic to our national biomedical research effort and are the type of questions which inherently guided planning in the old days at NIH. The question of the relation of the expenditures in biomedical research to total national health expenditures was never satisfactorily answered, although some attempts were made to rationalize this issue as well as the others. Needless to say, this set of questions needs to be constantly addressed, and the conclusions updated as the picture of health problems changes hopefully as the fruits of research are applied and new opportunities appear on the horizon.

This could be the agenda of the Planning Office of the NIH, with access to such explorations open to AAMC for critique and input, but this is unlikely and AAMC probably should develop its own capability for exploring these questions. The earlier Welt Committee and the Committee on Biomedical Research and Research Training which reports to the Committee on Financing Medical Education have tackled pieces of these issues.

C. HEALTH SERVICES

The issues set forth under Health Services deal with:

1. The role of the academic health (medical) center as a part of the health care system (local, regional, or national).
2. The priority assigned internally to this function from the standpoint of effort, time and resources devoted to it, and
3. The matter of how this function is financed both internally and externally.

Review of this set of issues leaves the uneasy feeling that these might not be the right issues for the AAMC, even though they may be the right ones for the institutions themselves. The "position" of the AAMC on what the institution chooses to be would probably be that it is the right of the institution to decide that. The objective of the AAMC would be to assist in enhancing the institution's capability for that type of self-determination and decision-making. That particular objective for AAMC is being achieved in part through the Management Advancement Program.

AAMC is presently engaged in the area of health services and questions related thereto through its Health Services Advisory Committee, its Subcommittee on Quality of Care and the newly formed Task Force on Primary Care. The set of issues these committees are dealing with could be looked at against the backdrop of the issues as stated in the YELLOW BOOK as one way of determining the AAMC view of priorities in the health services area. This situation could then be judged as appropriate or not in the light of the values of the COD Administrative Board.

D. THE FINANCING OF ACADEMIC HEALTH CENTERS

The issues in this set cannot be separated from the first

three sets of issues on Educational Activity, Biomedical Research, and Health Services. The first issue in this set is in the category of a given or an assumption. The second and third are both part of the question: Who should pay for what the academic health (medical) centers do; and the fourth asks how much or what share should eacy pay and why. The fifth asks how an understanding of the importance of the role of the academic health center can be promulgated and influence national decision-making so that its vitality and excellence can be maintained as a national resource.

The AAMC has a Committee on Financing Medical Education which submitted a preliminary report to the Assembly last November and is working toward a June 22nd deadline for submission of a final report to the Executive Council.

IV. The COD Administrative Board Agenda

This lengthy exercise was not intended to confuse, but to shed light on the nature of the issues in the YELLOW BOOK and look at them more carefully. The COD called for a green paper on these issues and a strategic plan for dealing with them. This paper is meant to assist the COD Administrative Board in arriving at a clear understanding of what the COD resolution implied in itself and what the implications are for the AAMC.

The recitation of the many AAMC committees at work in these various areas under consideration was not a veiled protest that AAMC was dealing with these issues anyway and the deans need not concern themselves with this matter. Rather, it was intended as a review of relevant present AAMC activities so that the Board is able to consider its recommendations in this context and develop a course of action which would be responsive to the needs of the

constituency as the Board perceives them.

These issues may not be those that COD believes address the appropriate problems for the longer range future. The discussion of strategy versus tactical approaches at the San Antonio meeting emphasized the frustration that some of the membership feels because of their perception that the AAMC uses the tactical approach. The COD may be expressing a belief (whether intuitive or informed) that appropriate "problem finding" is probably the most critical activity with which the leadership (group) or executive (group) of an organization can concern itself.

The COD Administrative Board could choose one of the following courses of action:

1. Transmit the COD resolution as is to the Executive Council without comment.
2. Transmit the COD resolution to the Executive Council with a recommended course of action for the Association.
3. Undertake an examination of the YELLOW BOOK ISSUES to determine if (or which of) these are the key matters for the constituency.
4. Do the examination suggested in 3. and recommend a course of action to AAMC for dealing with the issues so determined.

There are no doubt other alternatives the Board could follow. Just two years ago, the COD and the Administrative Board suggested that we undertake to identify and define the goals and objectives of the COD itself. It was ultimately decided that rather than pursue this somewhat difficult and perhaps nebulous undertaking at that time, that we rigorously attend to productive action programs aimed at substance, among them making the COD meetings worth coming to

(viz. Phoenix and San Antonio) and developing programs which help institutions generally and deans particularly deal with their real problems as they exist back home (viz. the Management Advancement Program. Actions of the COD have led to the AAMC work on quality assurance and greater attention to admissions problems. These efforts are specifically traceable to the actions of the COD and were actually undertaken in the face of some initial resistance.

Perhaps, now with this experience behind us, and with some record of success of these ventures, the COD Administrative Board is in a better position to devote further attention to identifying and defining its goals and objectives as an important part of AAMC and as the executive group of the COD. Action relative to the COD resolution or to the YELLOW BOOK ISSUES is a case in point. What objective is the COD pursuing in making the recommendation that AAMC develop a strategic plan regarding these issues?

In conclusion, it is hoped that the Administrative Board will have an opportunity to think on these matters before the June 21st meeting. It is intended, as directed by the Board at its last meeting, that the agenda will be devoted almost in its entirety to this matter. It is assumed that should the recommendation to the Executive Council be more than a simple transmittal of the COD resolution, that that recommendation or proposal can be hammered out at the June 21st meeting.

Medical Education, the Institutions, Characteristics, and Programs

A Background Paper
January, 1973

ISSUES

Educational Activity

1. Should national policy continue to support further expansion of medical education?

2. What should be the determinants of the rate and extent of any further expansion:

   . . . Perceived health care needs?

   . . . Volume of applicants?

   . . . Diminishment of dependence on foreign medical graduates?

3. What should be the distribution of responsibility (public-private, Federal-non-Federal) for the resources required for any further expansion:

   . . . In capital expenditure?

   . . . In continued operating support?

   . . . In assuring the availability of additional faculty?

4. How and by whom should acceptable qualitative levels of educational programs and performance be assured?

5. Should greater attention be given to national policy development for graduate clinical education, its financing and its role in the specialty and geographic distribution of physicians?

Biomedical Research

1. What should be the magnitude of our national effort in biomedical research?

2. How should this effort be related to:

   . . . National health expenditures;

   . . . National scientific capability as measured by good men and good ideas;

   . . . The rate of attack upon national health problems;

   . . . The national effort in health professional education?

3. What is the optimum ratio between the effort to advance knowledge and the effort needed to develop the insights which derive from such research into the technology required for the practical solution of national health problems?

4. How can we best cultivate the continuing new inflow of resources in trained men and adequate facilities to sustain biomedical scientific productivity in the years ahead?

Health Services

1. What is the appropriate distribution of effort in academic health centers between health services essential to the education of health professionals and health services undertaken in response to other social needs?

2. How can the ability of academic health centers to serve a regional educational and health service role be made most effective in reducing needless duplication of expensive facilities and restraining the proliferation of separate health occupations and functions?

3. How can the methods and terms of operating reimbursement and capital financing for hospital and health services in the teaching setting be developed so that they provide an adequate and viable financial base for their special functions?

The Financing of Academic Health Centers

1. The basic issue presented by the present-day status of academic medical center financing is how to assure long-term stable support for a set of complex but unified institutions with a basic long-term functional role in society in a context of short-term rapidly changing sources of funding.

2. Put another way, how should the responsibility for financing academic medical centers be distributed between the immediate beneficiaries of its activities (students, patients, program sponsors) and the long-term beneficiary of its function, society at-large, and the broad public and private roles therein?

3. The immediate corollary of this issue is the distribution of the public responsibility between the Federal and non-Federal public interests.

4. How should the amount of support from each beneficiary be determined--on an actual cost basis? If so, how can the joint cost problem be handled in distributing the cost burden among beneficiaries sharing in a common function? And how can the divisive effects of such a basis for determining institutional support be avoided?

5. Since these institutions are so dependent on each and every element of their income structure, how can external decisions to modify one element be made in such a way as to avoid major and unsettling perturbations throughout the entire entity?

V. AAMC Policy Statement - The Patient in the Teaching Setting.

The attached proposed AAMC Policy Statement will appear in the Executive Council agenda as an action item for adoption by that body. The item appears here to permit full COD discussion in advance of the Executive Council meeting.

The items following the statement are provided as background information. They include an AHA Statement on a Patient's Bill of Rights, a resolution adopted by the American Public Health Association on the Selection of Teaching Patients, and a statement detailing "Your Rights as a Patient at Beth Israel Hospital Boston".

Recommendation: That the Board endorse the adoption of this policy statement by the Executive Council.

AAMC POLICY STATEMENT

THE PATIENT IN THE TEACHING SETTING

The medical faculties and staff of the nation's medical schools and teaching hospitals are committed to the provision of the highest quality of personal health services. The interrelationship between the health care, educational and research functions of these institutions contribute to the assurance of these high standards of patient care. Patients seeking care in the teaching setting are not only provided high quality health services, but also an opportunity to share in the training of the nation's future health care professional personnel through participation in clinical education.

It is the policy of the Association of American Medical Colleges that all patients, regardless of economic status, service classification nature of illness or other categorization should have the opportunity to participate in the clinical education program of the hospital, clinic or other delivery setting to which they are admitted or from which they seek care.

In order to assure a single standard of high quality patient care, and to reinforce student perspectives and attitudes regarding patient rights and responsibilities, the AAMC reaffirms that:

- Selection of patients for participation in teaching programs shall not be based on the race or socio-economic status of the patient.

- Responsible physicians have the obligation to discuss with the patient both general and specific aspects of student participation in the medical care process.

- Provision of patient care is a confidential process. Relationships between the patient, health professional and student, regarding examinations, treatment, case discussion and consultations should be treated with due respect to the patient's right to privacy.

- Each patient has the right to be treated with respect and dignity. Individual differences, including cultural and educational background, must be recognized in designing each patient's care program.

- Every teaching institution should have programs and procedures whereby patient grievances can be addressed in responsive and timely fashion.

The Association of American Medical Colleges believes that the reaffirmation of these principles in medical schools and teaching hospitals will contribute to the best interests of patients and ensure the most appropriate educational environment for the training of future health professionals.

Affirmed by the Board of Trustees
of the
American Hospital Association
November 17, 1972

S74

35M-1/73-2959

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the

start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation,

service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.
11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

Statement on a Patient's Bill of Rights

87-4

RESOLUTIONS

Adopted by the GOVERNING COUNCIL of the AMERICAN PUBLIC HEALTH ASSOCIATION November 15, 1972

Group C—MANPOWER AND TRAINING

Increased Utilization of Dental Auxiliaries

Supporting Statement

The acute shortage of dental manpower in the United States cannot be alleviated economically solely by the training of additional numbers of dentists. Thus, the productivity of the available dentists must be increased. Although great advances in dental technology have been made in the past two decades, the major factor in increasing the productivity of dentists has been the increased use of dental auxiliaries. Recent studies have shown that properly trained auxiliaries can perform additional duties, maintain a comparable quality of services, and generate substantial increases in the productivity.

Resolution

The expanded utilization of dental auxiliaries appears to be the most practical, economical, and efficient approach to delivering high-quality dental care to more people.

The American Public Health Association recommends and urges that a program of federal support be implemented for the accelerated development of training programs to expand the function of dental auxiliaries, such programs to include support for construction of facilities, operation of programs, training of faculties, and financial incentives to dental schools that teach students the use of expanded function auxiliaries, and be it further resolved, that each state dental society and board of examiners be urged that formal programs of continuing education be developed to prepare presently practicing dentists to utilize expanded function auxiliaries.

Expanded Role of the Nurse in Health Care

Traditional patterns in the delivery of health care are changing rapidly. One of the most positive and potentially beneficial innovations in personnel utilization involves the expanded role of the nurse in primary care.

This concept, which was accepted by APHA's Governing Council in 1970, has gained widespread support from the health community, as well as the public. However there has been an unplanned proliferation of short-term training programs to prepare nurse practitioners without the concomitant development of standards to provide adequate safeguards for the practitioner and the public.

APHA reaffirms and extends its position in regard to the utilization of the nurse in extended medical and nursing functions. Specifically, APHA recommends that:

- The expanded role of nurses in medical and health care be developed jointly by the professionals in medicine and nursing;
- Guidelines and standards for programs to prepare the nurse in an expanded role should continue to be developed and refined by national nursing organizations and medical specialty groups;
- Experimentation continue under the auspices of duly accredited institutions;
- Affiliates stimulate the development of responsible educational programs within established guidelines and the appropriate use of practitioners who have successfully completed such programs.

Selection of Teaching Patients

For over a century most of the patients chosen for clinical teaching in medicine, dentistry, and other related health fields, have been so selected, directly or indirectly, because they are poor. In addition, the majority of these patients have been designated as teaching cases without choice on their part. The justification of such selection has been that teaching services have provided health care services to many who could not have otherwise afforded it. While there are still many who cannot obtain adequate health care, the American Public Health Association considers this means of designating patients for clinical teaching programs undesirable.

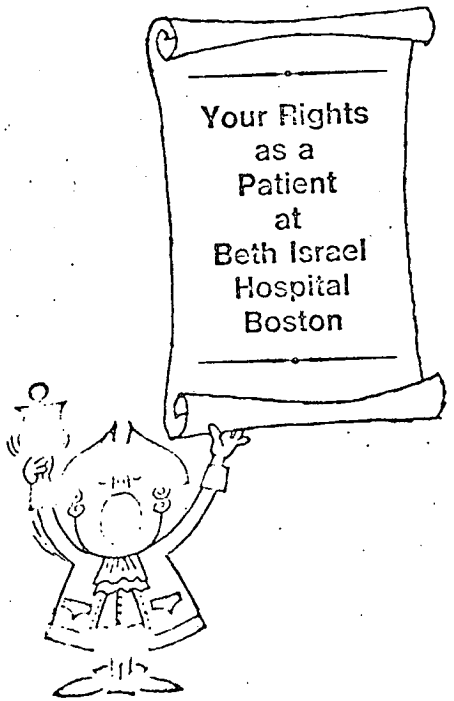
The present means of selecting teaching patients perpetuates a two-class health system which is based upon income and social status. Not only is this socially undesirable, but it is particularly inappropriate in settings where student practitioners are developing perspectives which will persist throughout their professional lives. Most important, however, selection based on economic criteria as inconsistent with the goal of APHA to assure equality of access to and quality of health care for all.

APHA urges the American Medical Association, American Osteopathic Association, the American Hospital Association, the American Dental Association, the American Association of Dental Schools, the Association of American Medical Colleges, the National League for Nursing, and other appropriate professional associations to join with APHA in instituting such resolutions as:

1. Participation of all patients in clinical teaching programs shall be based on the prior approval by each patient and
2. Selection of patients for teaching programs shall not be based on the race or socioeconomic status of the patient.

Restoration of Environmental Manpower Training Funds

The Environmental Protection Agency, in response to an apparent surplus of certain types of engineers, has curtailed funds designated for graduate level, professional training of categorical specialties in such fields as solid wastes management, radiation protection, water pollution control, and air pollution control.



Beth Israel Hospital, its doctors, nurses and entire staff are committed to assure you excellent care as our patient. It has always been our policy to respect your individuality and your dignity. This listing is published to be certain that you know of the long-standing rights that are yours as a Beth Israel patient.

1. You have the right to the best care medically indicated for your problem, that is, to the most appropriate treatment available without considerations such as race, color, religion, national origin or the source of payment for your care.

2. You have the right to be treated respectfully by others; to be addressed by your proper name and without undue familiarity; to be listened to when you have a question or desire more information and to receive an appropriate and helpful response.

3. You have the right to expect that your individuality will be respected and that differences in cultural and educational background will be taken into account.

4. You have the right to privacy. In the clinics, you should be able to talk with your doctor, nurse, other health worker or an administrative officer in private, and know that the information you supply will not be overheard nor given to others without your permission. In the Hospital, when you are in a semi-private room, you can expect a reasonable attempt to keep the

conversation private. When you are examined, you are entitled to privacy — to have the curtains drawn, to know what role any observer may have in your care, to have any observers unrelated to your care leave if you so request. If you are hospitalized, no outsiders can see you without your permission. Your hospital records are private as well; and no person or agency beyond those caring for you can learn the information in your medical record without your specific permission.

5. You have the right to know the name of the doctor who is responsible for your care; to talk with that doctor and any others who give you care; to receive all the information necessary for you to understand your medical problems, the planned course of treatment (including a full explanation about each day's procedures and tests) and the prognosis or medical outlook for your future; to receive adequate instruction in self-care, prevention of disability and maintenance of health. You have the right to ask the doctor any questions that concern you about your health. You have the right to know who will perform a test or an operation, and the right to refuse it. Because this is a university hospital, you may come across doctors, nurses and other health workers in training, or you may be asked to participate in special studies. We believe that the presence of students adds to the quality of care. Nevertheless, you have the right to have a full explanation of any research study or any training program for students before you agree to participate in it, and the right to refuse to participate. If you

agree to the diagnostic and therapeutic procedures recommended by your doctor, you may be asked to sign a consent form, but if you refuse, you have the right to receive the best help that the Hospital can still offer under the circumstances.

6. You have the right to leave the Hospital even if your doctors advise against it, unless you have certain infectious diseases which may influence the health of others, or if you are incapable of maintaining your own safety, as defined by law. If you do decide to leave before the doctors advise, the Hospital will not be responsible for any harm that this may cause you and you will be asked to sign a "Discharge Against Advice" form.

7. You have the right to inquire about the possibility of financial aid to help in the payment of your Hospital bills and the right to receive information and assistance in securing such aid.

Patients also have certain responsibilities which should be carried out in their own best interests:

Please keep appointments, or telephone the Hospital when you cannot keep a scheduled appointment; bring with you information about past illnesses, hospitalizations, medications and other matters relating to your health; be open and honest with us about instructions you receive concerning your health, that is, let us know immediately if you do not understand

them or if you feel that the instructions are such that you cannot follow them.

You have the responsibility to be considerate of other patients, and to see that your visitors are considerate as well, particularly with reference to noise and smoking, which are usually very annoying to nearby patients.

You also have a responsibility to be prompt about payment of Hospital bills, to provide information necessary for insurance processing of your bills, and to be prompt about asking any questions you may have concerning your bills.

Beth Israel Hospital is interested in keeping you in the best health possible. If you feel you are not being treated fairly or properly, you have the right to discuss this with your doctor, nurse, unit manager, other health worker, or the Administrator on Call. You may also write a letter to the General Director of Beth Israel Hospital, Boston 02215. All correspondence will receive prompt and personal attention.

This message reflects the interest and philosophy of the entire staff of Beth Israel Hospital.

Mitchell T. Rabkin, M.D.
General Director

VI. Review of the Closeout of the Freestanding Internship

By the attached letter, Dr. Buchanan has requested that the COD Administrative Board review the closeout of the free-standing interships. One of the problems cited by Dr. Buchanan is the increasing number of students who did not match for internships this year. Summary data on the NIRMP follows the letter.

CORNELL UNIVERSITY
MEDICAL COLLEGE
1300 YORK AVENUE
NEW YORK, N. Y. 10021

MAY 9 1973

OFFICE OF THE DEAN

May 4, 1973

Marjorie P. Wilson, M.D.
Director
Department of Institutional Development
Association of American Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D. C. 20036

Dear Marjorie:

Several recent events have focused my attention on the need to review the closeout of the freestanding internship scheduled for 1975. These events include:

a. This year we experienced a sharp increase in the number of our students who did not match for internships. This also occurred at several other established and respected schools with which I am familiar.

   In the course of our efforts to place these individuals, we discovered far fewer unmatched hospital positions than in former years. This undoubtedly reflects the influx of American citizens from foreign medical schools and the accomplished closure of many internships of the freestanding variety.

b. Many specialty residency directors are urging applicants to take a year of general, "mixed" or rotating internships before entering specialty training. This creates a special demand for one-year programs more commonly found in the "freestanding" state than in major teaching centers where the first and second postdoctoral years of general surgery and internal medicine programs are commonly coupled.

c. The requirements of the Academy of Family Practice are presently so inflexible as to threaten well-established mixed internships in many of the larger community hospitals where a family practice residency would otherwise be the logical solution to the problem. This situation exists in Duluth, Minnesota and though it is critical to the new medical school there, a satisfactory outcome probably cannot be negotiated before the 1975 deadline.

d. The demise of NIH support for clinical fellowships will increase the demand for residency openings which are not likely to be made available in our university medical teaching centers because of the current fiscal crisis. Thus, a solution we should be seeking is the establishment of more residency programs, the majority geared to produce "generalists" rather than simply to abolish freestanding internships. This would, of course, require our community hospitals to spend money on staffing such programs but it would also greatly improve the quality of medicine in those communities while meeting a growing national need in medical education.

The foregoing is but a partial discussion of a very important constellation of issues related to the future of freestanding internships. I would, therefore, request that this item be placed on the agenda for the June 1973 meeting of the COD Administrative Board.

Thank you.

Sincerely,

J. Robert Buchanan, M.D.
Dean

JRB:hw

	PROGRAM XXII 1973-74	PROGRAM XXI 1972-73	PROGRAM XX 1971-72	PROGRAM XIX 1970-71
PARTICIPANTS	13,452	10,765	9,846	9,006
Matched	10,635	9,044	8,599	8,113
Unmatched	1,219	498	405	274
X'ed All Choices	162	144	150	140
Did Not Return List	1,110	486	368	174
Withdrew	326	593	324	305
TOTAL MATCHED	10,635	9,044	8,599	8,113
U.S. Medical Schools	8,969	8,389	8,107	7,732
McGill	15	18	23	23
Other Canadian Schools	48	40	42	60
Foreign	1,004	490	301	244
Unclassified	19	18	17	11
Osteopaths	107	89	109	43
Fifth Pathway	55			
M.D. Radiology Candidates	418			
TOTAL UNMATCHED	1,219	498	405	274
U.S. Medical Schools	556	369	310	218
McGill	4	0	2	0
Other Canadian Schools	13	12	2	1
Foreign	460	94	60	39
Unclassified	4	1	2	0
Osteopaths	27	22	29	16
Fifth Pathway	5			
M.D. Radiology Candidates	150			
TOTAL X'ED ALL CHOICES	162	144	150	140
U. S. Medical Schools	86	104	105	96
McGill	0	2	2	5
Other Canadian Schools	3	1	2	1
Foreign	46	25	32	35
Unclassified	4	0	1	0
Osteopaths	3	12	8	3
Fifth Pathway	3			
M.D. Radiology Candidates	17			
TOTAL DID NOT RETURN LIST	1,110	486	368	174
U.S. Medical Schools	316	107	66	26
McGill	7	7	17	4
Other Canadian Schools	15	15	7	8
Foreign	499	283	202	122
Unclassified	15	8	5	7
Osteopaths	58	66	71	7
Fifth Pathway	9			
M.D. RAdiology Candidates	191			
TOTAL WITHDREW	326	593	324	305
U.S. Medical Schools	198	525	270	255
McGill	3	3	2	17
Other Canadian Schools	1	1	7	1
Foreign	82	55	29	30
Unclassified	2	4	1	1
Osteopaths	3	5	15	1
Fifth Pathway	1			
M.D. Radiology Candidates	36			

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

	PROGRAM XXII 1973-74	PROGRAM XXI 1972-73	PROGRAM XX 1971-72	PROGRAM XIX 1970-71
U.S. Medical Schools	10,125	9,494	8,858	8,327
Matched	8,969	8,389	8,107	7,732
Unmatched	556	369	310	218
X'ed All Choices	86	104	105	96
Did Not Return List	316	107	66	26
Withdrew	198	525	270	255
McGill Medical School	29	30	46	49
Matched	15	18	23	23
Unmatched	4	0	2	0
X'ed All Choices	0	2	2	5
Did Not Return List	7	7	17	4
Withdrew	3	3	2	17
Other Canadian Schools	80	69	60	71
Matched	48	40	42	60
Unmatched	13	12	2	1
X'ed All Choices	3	1	2	1
Did Not Return List	15	15	7	8
Withdrew	1	1	7	1
Foreign	2,091	947	624	470
Matched	1,004	490	301	244
Unmatched	460	94	60	39
X'ed All Choices	46	25	32	35
Did Not Return List	499	283	202	122
Withdrew	82	55	29	30
Unclassified	44	31	26	19
Matched	19	18	17	11
Unmatched	4	1	2	0
X'ed All Choices	4	0	1	0
Did Not Return List	15	8	5	7
Withdrew	2	4	1	1
Osteopaths	198	194	232	70
Matched	107	89	109	43
Unmatched	27	22	29	16
X'ed All Choices	3	12	8	3
Did Not Return List	58	66	71	7
Withdrew	3	5	15	1
Fifth Pathway	73			
Matched	55			
Unmatched	5			
X'ed All Choices	3			
Did Not Return List	9			
Withdrew	1			
M.D. Radiology Candidates	812			
Matched	418			
Unmatched	150			
X'ed All Choices	17			
Did Not Return List	191			
Withdrew	36			

VII. Moonlighting House Officers

Dr. Mellinkoff requested that this item be considered by the Administrative Board. A summary of his concerns follows:

"I have recently discovered that moonlighting by house-officers is an extremely widespread practice in Los Angeles and I understand across the country. Should the AAMC or the COD take a position on the compatibility of moonlighting with approved internship and residency programs? If it is judged to be compatible, under what circumstances? To contend with what I see as a trend, I believe the individual institutions need a national policy statement dealing with this issue."

The AAMC, through the Council of Teaching Hospitals has conducted a Survey of House Staff Policy. Section C of the Survey deals with House Officer Employment Policies. If there are sufficient responses to permit tabulation by the June 21 meeting, the results will be submitted to the Administrative Board.

Following the Survey in this section of the agenda book is an SSA Part B Intermediary Manual Revision which will permit licensed house officers to be reimbursed for professional services performed outside their regular training program in another hospital.

COTH Survey of House Staff Policy

March 1973

To Be Completed and Returned to:

COTH-AAMC, One Dupont Circle, N.W., Washington, D. C. 20036

HOSPITAL NAME: _____

A. INTERNS AND RESIDENTS

For the purpose of this survey, please report as follows: Intern = 1st post-MD year; 1st year resident = 2nd post-MD year; etc.

	Interns	Residents	Clinical Fellows	Total
1. How many house staff positions did you fill in 1972-1973?				
2. How many house staff positions are you offering for 1973-1974? (If you share house staff with another institution, please estimate the full-time equivalencies for your hospital)				

3. What is the minimum cash stipend per year?

1973-74 stipends are estimated:

Yes _____

No _____

Cannot Estimate _____

	1972-73	1973-74
1st Post-MD year:	$ _____	$ _____
2nd post MD year	_____	_____
3rd post MD year	_____	_____
4th post MD year	_____	_____
5th post MD year	_____	_____
6th post MD year	_____	_____
Clinical Fellowships: 1st year	_____	_____
2nd year	_____	_____

4. If minimum stipends vary by department, in which departments do they vary, and how much in 1972-73 was the difference for *2nd post MD year?*

	Departments	$Amount
a.	_____	+ _____
b.	_____	+ _____
c.	_____	+ _____
d.	_____	+ _____

5. Do you have a dependency allowance? YES_____ NO _____

6. What is the estimated total dollars to be spent for intern and residents' stipends for 1972-73? $_____

7. What is the estimated cost of fringe benefits (including insurance) to your institution for house staff during 1972-73? $_____

8. What percent of your 1972-73 operational budget is allocated to the costs of stipends and fringe benefits for house staff? _____ %

9. What sources are used to pay your costs (stipends and fringe benefits) for interns and residents? (i.e. hospital charges, federal grants, medical school funds)

	Sources	$	% of Contribution
a.	_____	_____	_____ %
b.	_____	_____	_____ %
c.	_____	_____	_____ %

10. What sources are used to pay your costs for clinical fellowships?

	Sources	$	% of Contribution
a.	_____	_____	_____ %
b.	_____	_____	_____ %
c.	_____	_____	_____ %

11. Will there be a change in the total number of funded house officer positions for July, 1973? Net Number Increased _____

Net Number Decreased _____

No Change _____

B. FRINGE BENEFITS

1. Please check the health insurance benefits for which you pay the *full* costs of the premiums to insure . . . .

	House Officers	Dependents
Hospitalization	_____	_____
Medical Surgical	_____	_____
Major Medical	_____	_____

2. Please indicate the perquisites which you furnish at *reduced rates or at no cost* to your house officers.

_____ Laundry
_____ Duty Uniforms
_____ Parking
_____ Malpractice Insurance
_____ Life Insurance: Face Value of Policy $ _____
_____ Other: (please specify): _____
_____ None of the above mentioned
_____ Professional Meetings (travel, room or board)
_____ Housing (cash allowances or domicile)
_____ Meals (other than on-call or snacks)

3. How many weeks of vacation are available to *2nd year Post-MD's*? _____ weeks

4. During the past year, which fringe benefits were:

Added?	Increased?	Eliminated?	Decreased?
_____	_____	_____	_____
_____	_____	_____	_____

C. HOUSE OFFICER EMPLOYMENT POLICIES

1. In addition to their regularly prescribed duties, are your house officers permitted to engage in the delivery of other medical services *at your hospital,* such as staffing your emergency room, for which they earn additional money (moonlighting)? YES _____ NO _____

2. Does your hospital policy permit house officers to "moonlight" outside your institution? YES _____ NO _____

3. If NO, is the policy strictly enforced? YES _____ NO _____

4. Does your hospital ever hire house officers from other institutions to staff your emergency room or a similar service? YES _____ NO _____

D. COLLECTIVE BARGAINING

1. Has your hospital, since January 1, 1972, received a request for *collective bargaining recognition* from any formally constituted group seeking to represent your house staff regarding wages, fringe benefits, and/or terms and conditions of employment? YES _____ NO _____

2. Does your hospital now have a negotiated *collective bargaining contract* with any segment of your house staff regarding wages, fringe benefits, and/or terms and conditions of employment? YES _____ NO _____

3. Has your hospital, since January 1, 1972, experienced any type of job action (e.g., work stoppage, strike, "admit-in," mass resignation, "sick-out," etc.) by any segment of your house staff? YES _____ NO _____

4. Is any portion of your non-house staff personnel (full-time physician faculty, nurses, paramedical, non-professional) covered by a negotiated collective bargaining contract? YES _____ NO _____

E. OTHER

1. What is the procedure in the following two departments for "nights on"?

a. In *Medicine,* 2nd year Post-MD's are assigned a "night on" every _____ weekday and every _____ weekend.

b. In *Surgery,* 2nd year Post-MD's are assigned a "night on" every _____ weekday and every _____ weekend.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

PART B

March 1973

INTERMEDIARY MANUAL
REVISION TRANSMITTAL NO. 320

New Material	Page No.	Replaced Pages
Sec. 6102.6-6102.8	21-21.1 (2 pp.)	21-21.1 (2 pp.)

Section 6102.7, Interns and Residents, has been revised to include within the definition of "physicians' services" services performed by interns and residents outside their regular training program in a hospital other than the hospital in which they are in training under such program provided that they are fully licensed to practice medicine in the State in which the services are rendered and are not compensated by a provider. Any services rendered in the hospital with the approved teaching program under which the interns or residents are in training continue to be reimbursable, if at all, only as provider services. This policy is effective on receipt and is applicable to claims not yet adjudicated as well as to adjudicated claims coming to the carriers' attention. Files should not be searched, however, to locate previously denied claims.

Thomas M. Tierney, Director
Bureau of Health Insurance

Action Note: Add to the last paragraph of § 6012, "(See, however, § 6102.7B regarding circumstances under which services of certain moonlighting residents are reimbursable on a reasonable charge basis.)"

6102.6 Provider-Based Physicians' Services.--The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, etc., whether or not they bill patients directly) include two distinct elements: the patient-care componenet, and the provider component. (The services of interns and residents are reimbursable to the provider on a reasonable cost basis even though the intern or resident is a licensed physician.)

A. The Professional Component.--The patient-care component of provider-based physicians' services includes those services directly related to the medical care of the individual patient. (No Part B charge can be recognized for autopsy services.) When such services are performed by a faculty member of a medical, osteopathic, dental, or podiatry school billing may be by the school with the physician's authorization. See § 6330 for form and procedures for billing for services of provider-based physicians. See § A6015 for limitations on reassignment under the 1972 Amendments.

B. The Provider Component.--Provider-based physicians often perform professional services other than those directly related to the medical care of individual patients. These may involve teaching, administrative, and autopsy services, and other services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs. Reimbursement for such costs is made under Part A where they relate to inpatient services and under Part B where they relate to outpatient services and inpatient ancillary services where there are no benefits payable under Part A. (See § 6852.2 on distinguishing between professional and provider components for reimbursable purpose.)

C. The Roles of the Fiscal Intermediary and Carrier.--The provider's Part A intermediary will obtain from the provider information it and the Part B carrier need to make payment determinations where the services of provider-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between provider and physician on the allocation of physician compensation (received from or through the provider) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the provider and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue (§ 6852.6). The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of provider-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, the uniform percentage if the optional method of determination is used, or the unit charge if the per diem or per visit method is used (§§ 6856ff.).

Group practice prepayment plans which deal directly with the Social Security Administration may make a written agreement with a hospital, or with physicians in a hospital, to reimburse the professional component of the hospital-based physician's charge for services to plan members entitled to Part B. These claims will not be processed by carriers.

6102.7 Interns and Residents.--

A. General.--For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting (e.g., unlicensed graduates of foreign medical schools). As a general rule, services of interns and residents are reimbursed on a reasonable cost basis by the Part A intermediary. However, the services of an intern or resident are reimbursable by the carrier on a reasonable charge basis as physicians' services where the individual: (1) renders the services off provider premises (however, see also B below, regarding certain "moonlighting" interns and residents); (2) is not compensated by a provider; and (3) is fully licensed to practice medicine by the State in which the services are performed. (See §§ 6704.5 and 6806 regarding the reasonable charge determination.)

See §§ 3101.6 and 3115 of the Part A Intermediary Manual (HIM-13) regarding approved programs and coverage as a provider service under hospital and medical insurance.

B. "Moonlighting" Interns and Residents.--Services a moonlighting intern or resident performs in the outpatient department or emergency room of the hospital which has the training program in which he is participating are reimbursable only on a Part B reasonable cost basis (i.e., all services performed in the hospital with the training program are treated as part of the training program). In addition, any services a "moonlighting" intern or resident furnishes in the hospital other than the one with the approved training program under which the intern or resident is in training are reimbursable on a Part B reasonable cost basis if he is paid for such services on a salary or other fixed compensation basis by the hospital in which such services are rendered (or by another hospital). However, such services are reimbursable by the carrier on a reasonable charge basis as physicians' services if the intern or resident is not so compensated and if he is fully licensed to practice medicine in the State in which the services are performed.

6102.8 Supervising Physicians in the Teaching Setting.--Medical insurance covers the services attending physicians (other than interns and residents) render in the teaching setting to individual patients.

ROLE OF OSR AND GSA REPRESENTATIVES IN MONITORING PROCEDURES OF THE NATIONAL INTERN AND RESIDENT MATCHING PROGRAM (NIRMP)

Background

At its business meeting in November 1972, the AAMC Group on Student Affairs (GSA) adopted a resolution urging that the National Intern and Resident Matching Program (NIRMP) improve its enforcement of the "all or none" principle for hospital participation in the program. Similarly, at its November business meeting, the AAMC Organization of Student Representatives (OSR) adopted a resolution to establish a system of investigating NIRMP violations and reporting them to appropriate authorities.

In response to these actions, staff of the Division of Student Affairs developed a proposal for the role of OSR and GSA representatives in monitoring the procedures of NIRMP. This staff proposal was approved in principle by Western OSR and GSA members at their regional meeting in Asilomar, California, in March.

The program outlined below, which is a modification of the original staff proposal, was drafted and approved by the Southern region of OSR at its meeting in Williamsburg in April. This program was subsequently supported in principle by Southern GSA at the same meeting.

The basic elements of the Southern region's NIRMP monitoring program were also approved by the Central region of OSR at its meeting in Starved Rock, Illinois, in May. Just prior to this meeting, the NIRMP Board of Directors had agreed that one of its three student members could be appointed by the OSR Administrative Board, so the Central region version of these procedures included the concept that the OSR National NIRMP Monitor would also be a member of the NIRMP Board. Central region OSR also suggested that the Coordinating Council for Graduate Medical Education be included among the recipients of violation reports in lieu of the AAMC Executive Committee and developed a procedure under which CCGME could eventually deny accreditation to any institution of graduate medical education having a program found to be in repeated violation of NIRMP rules. Central GSA approved the Central OSR version of the basic monitoring program but did not act on those portions of the Central OSR proposal concerning accreditation.

It is presently planned that AAMC will assume all staffing responsibility for the functions of the OSR National NIRMP Monitor. Reports of violations will be sent to the Monitor at AAMC Headquarters and AAMC staff will conduct correspondence and take action as appropriate in his/her name, with copies of all materials forwarded to the Monitor.

At its meeting on June 8, the OSR Administrative Board expects to develop a final proposal for OSR monitoring of NIRMP violations, based on the versions approved by OSR and GSA in the three regions which have met this spring, and to select an OSR National NIRMP Monitor for the coming year. Assuming Executive Council approval of this program, the final proposal and the name of the Monitor would be promptly circulated to GSA and OSR members, so implementation of the OSR role in monitoring NIRMP violations may begin this summer.

Program

(1) The role of the AAMC Organization of Student Representatives and Group on Student Affairs in assisting in the maintenance of the NIRMP should be mainly one of channeling student reports of non-compliance to a committee established to review such problems by the dean of each medical school.

(2) The membership of this committee shall include a representative of the OSR and of the GSA as well as any other members appointed by the dean.

(3) When the NIRMP is explained to the rising seniors, the importance of working within established procedures should be stressed to them by this committee. Students shall be asked to report to any member of this committee evidence of any internship or first-year graduate program trying to seek contract agreements outside of the established arrangement for matching.

(4) The committee shall (a) guarantee anonymity to a complaining student, and (b) be responsible for securing all pertinent data in a form pre-established by the complaint review committee. As necessary, any committee member may request a meeting of the committee to determine whether data submitted merit follow-up. If it is agreed that violations exist and that the hospital program in question does not intend to abide by its contract agreements, the committee will (a) advise the dean, and (b) report the violating hospital and department to the OSR National NIRMP Monitor.

(5) The OSR Monitor shall send a report of such violations to the NIRMP Board of Directors and to the AAMC Executive Committee. This report shall state only that X number of various types of violations have been reported concerning Institution Y, Department Z. The Monitor will request that NIRMP acknowledge receipt of such reports and advise him that appropriate action will be taken. It shall then be up to the NIRMP to see that prompt appropriate action is taken by them and/or by the AAMC Executive Committee as needed.

(6) If the National Monitor has reason to believe that appropriate action on a reported violation is not being taken by NIRMP, the Monitor may at his discretion resubmit the report in question to the NIRMP Board of Directors, indicating that this is a second notice.

(7) The National Monitor shall determine, by the time of the AAMC annual meeting, whether (a) all reports of violations forwarded to the NIRMP Board of Directors and AAMC Executive Committee have been received, and (b) the NIRMP has taken action on them. The Monitor shall report these results at the OSR annual meeting.

(8) The OSR Monitor shall be selected by a majority vote of the OSR Administrative Board during the annual meeting. Assuming agreement with this procedure by the Central and Northeast GSA and OSR at their 1973 regional meetings, a temporary National Monitor will be appointed by the OSR national chairman to serve until the 1973 OSR annual meeting.

(9) This procedure shall be reviewed every three years.

IX. Annual Meeting Agenda Items

In addition to the previously considered COD Business Meeting agenda items, the following requests for COD meeting time have been submitted:

1) by the VA - a suggested joint COD - VA meeting similar to last years;
2) by John Mills of the National Fund for Medical Education; a request that he be given time to address the COD. The following memorandums address these matters more fully.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SERVICE EDUCATION RESEARCH

INTER-OFFICE MEMO

Retain – 6 mos. ☐
1 yr. ☐
5 yrs. ☐
Permanently ☐
Follow-up Date

DATE June 4, 1973

TO: Marjorie Wilson, M.D.

FROM: Bart Waldman

SUBJECT: Proposed COD/VA Joint Meeting

Ed Friedlander of the Veterans Administration telephoned today and proposed that the Council of Deans again hold a joint session with the VA at this year's Annual Meeting. After casually mentioning a few eight-place figures (as VA funds available to the medical schools) and reminding me of how many deans were upset at having missed Dr. Musser's exposition last year, Ed made a strong plea for a Monday, Tuesday or Wednesday session.

If the deans are agreeable to such a session, I would recommend the following alternative dates and time (in order of preference):

1. Monday, 4:30-6:30 - This would mean cutting the COD Business Meeting short, but would yield the best attendance.

2. Wednesday, " " - This would cut into the tail end of the "Assessment" program and might also find some dean en route home.

3. Sunday afternoon or evening - Ed seemed dead-set against meeting again on the day on which most deans arrive.

4. Tuesday evening 8:30-10:30 - The bias against evening meetings is hard to predict; attendance might suffer.

I would appreciate if if you could have this nailed down by the completion of the June COD Administrative Board Meeting.

cc: Joe Keyes

COPIES TO:

NATIONAL FUND FOR MEDICAL EDUCATION

Office of the President
100 University Circle Research Center
11000 Cedar Avenue, Room 212
Cleveland, Ohio 44106 • Telephone 216-791-1445

May 29, 1973

Marjorie P. Wilson, M.D.
Director of Institutional Development
Association of American Medical Colleges
1 Dupont Circle, N.W. - Suite 200
Washington, D. C. 20036

Dear Dr. Wilson:

Mr. Charles Fentress, Public Relations Officer of AAMC and Mr. Jay Nelson Tuck of the National Fund for Medical Education have been working with the Public Relations Group of the Association. They have suggested that it might be helpful if I spoke briefly to the Council of Deans to explain the interest of the National Fund in promoting a much wider public understanding of the current financial crisis of our medical schools and the collaborative program which Mr. Tuck, Mr. Fentress and others have initiated

The purpose of this letter is to inquire whether the Council of Deans wishes to have me appear at its session in November in connection with the Annual Meeting.

The National Fund for Medical Education is engaged in a program of public information as a means of increasing public understanding and concern for our medical schools and their several problems particularly those of a financial nature. One of the activities of the program is to assist the medical schools of a limited geographic region to obtain access to mass media on a collaborative basis. Currently Mr. Tuck is working with the medical schools in Illinois and Michigan.

I trust that you will find it possible to make the proper inquiries and inform me as to whether the Council of Deans wishes to talk with me.

Sincerely yours,

John S. Millis

John S. Millis
President

EXPIRING LEGISLATION

Following is a listing of health legislation expiring 6/30/73 and the various legislative approaches for dealing with these expiring authorities:

	HEALTH LEGISLATION EXPIRING 6/30/73:	FY 1974 FUNDS REQUESTED:	ADMINISTRATION LEGISLATION:	CONGRESSIONAL LEGISLATION:	INCLUDED IN OMNIBUS BILLS S 1136/HR 7806:
PUBLIC HEALTH SERVICE ACT	Health Services Research, Development (Sec. 304)	Yes	S 1633 HR 6590	HR 7274	Yes
	Health Statistics (Sec. 305)	Yes	S 1515 HR 6586	HR 7274	Yes
	Public Health Training (Sec. 306 and 309)	No			Yes
	Migrant Health (Sec. 310)	Yes	to be supported through 314(e)		Yes
	Comprehensive Health Planning (Sec. 314)	Yes	S 1632 HR 6588		Yes
	Medical Libraries (Sec. 393-398)	Yes	S 1450 HR 6387	HR 7274	Yes
	Hill-Burton Construction, Modernization (Title VI)	No		S 1006	Yes
	Allied Health Training (Title VII , Part G)	No			Yes
	Regional Medical Programs (Title IX)	No			Yes
	Population Research and Family Planning (Title X)	Yes	to be supported through 314(e)		Yes
CMHC ACT	Developmental Disabilities (Title I)	Yes	S 1654 HR 6589		Yes
	Community Mental Health Centers (Title II, Part A,B)	Yes	S 1634 HR 6587		Yes
	Alcohol and Drug Abuse (Title II, Parts C,D,E)	Yes			Yes
	Mental Health of Children (Title II, Part F)	Yes			Yes
PL 91-296	Mandatory Spending (Sec. 601)	NA			Yes
SSA	Maternal & Child Health Project Grants (Title V)	No		S 1543 HR 708	No

STATUS OF LEGISLATIVE APPROACHES:

Labor-HEW Appropriations, FY 1974: hearings underway in Senate and House.

Senate bills:

S 1006 pending before health subcommittee
1136 cleared for Presidential action 6/5
1450 pending before health subcommittee
1515 pending before health subcommittee
1543 pending before finance committee
1632 pending before health subcommittee
1633 pending before health subcommittee
1634 pending before health subcommittee
1654 pending before health subcommittee

House bills:

HR 708 pending before health subcommittee
(7806) cleared for Presidential action as S 1136
6387 considered with HR 7274
6586 considered with HR 7274
6587 pending before health subcommittee
6588 considered with HR 5608 and HR 7274
6589 pending before health subcommittee
6590 considered with HR 7274
7274 hearings concluded, health subcommittee

6/5/73