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COUNCIL OF DEANS
ADMINISTRATIVE BOARD

AAMC Conference Room
Thursday, September 13, 1973
9:00 a.m. - 3:00 p.m.

AGENDA

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12:30 p.m.
JOINT COD-CAS-COTH ADMINISTRATIVE BOARDS
Luncheon
Dupont Plaza Hotel
SPECIAL REPORT OF THE PRESIDENT

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

June 21, 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.
William Maloney, M.D.
William Mayer, M.D.
Sherman M. Mellinkoff, M.D.

(Staff)

John A. D. Cooper, M.D.*
Evelyn Harrison
Joseph Keyes
James R. Schofield, M.D.
Bart Waldman
Marjorie P. Wilson, M.D.

(Guest)

Charles Sprague, M.D.*
Elliott Ray*

ABSENT:

Andrew Hunt, M.D.
Emanuel M. Papper, M.D.
Robert L. Van Citters, M.D.

I. Call to Order

Dr. Mellinkoff, Chairman, called the meeting to order shortly after 9:00 a.m.

II. Minutes of the Previous Meeting

The minutes of the March 15, 1973 meeting of the Council of Deans Administrative Board were approved as circulated in the Agenda Book, with the correction of two typographical errors on page 5 of the minutes.

III. Chairman's Remarks

Dr. Mellinkoff discussed the appointment and work of the Council of Deans Nominating Committee. He noted that the COD Rules and Regulations require that the committee solicit the recommendations that the Council members or nominations to fill existing vacancies. He remarked that the returns were somewhat disappointing in that only 34 of 114 advisory ballets had been received.

*Present for only a portion of the meeting.

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Dr. Mellinkoff distributed to the members of the Board a one-page document entitled "Notes on the Regional Medical Library Program," which appears as an appendix to these minutes. This document was an enclosure to a letter to Dr. Mellinkoff from Dr. Harold Schoolman, which suggested that the COD annual meeting might be an appropriate forum to address certain issues emerging from the program evaluation now underway involving site visits to each of the regional medical libraries. Dr. Schoolman suggests that while the librarians are aware of the program and are cooperating with it, the administrative heads of the institutions do not seem to be aware or fully appreciate the commitments that are being made. Several board members commented that the paper presents a distorted view of the problem, at least as perceived by them. In their view, many librarians appear to be threatened by regional arrangements. The administrative heads on the other hand, while interested in the services, find them available only at a price which the schools can not afford. In their view, the programs which are successfully providing services, are doing so only at a substantial expense to the sponsoring institution. The Board was amenable to devoting some time at the Council of Deans meeting to a discussion of these issues. It was agreed, however, that there should be a preliminary meeting at the staff level to more precisely define the problems to be addressed.

IV. Consideration of Follow-Up Action on the San Antonio Resolution

At the Spring Meeting of the COD in San Antonio the following resolution was adopted:

> "The Council of Deans recommends that the Executive Council direct the revision and expansion of the paper entitled, Medical Education: The Institutions, Characteristics and Programs, 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."

The Board had devoted a portion of its March 15 meeting to a consideration of this resolution and the appropriateness of making a recommendation to the Executive Council regarding its implementation. At that meeting the Board con-

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cluded that it should devote a major portion of its June meeting to this question, and requested that the staff develop appropriate background material.

The Agenda Book contained a discussion paper prepared by staff with appropriate technical advice. Dr. Mellinkoff opened the discussion by requesting that Dr. Wilson highlight the material in the discussion paper.

Dr. Wilson pointed out that the San Antonio discussions included a number of comments expressing a felt need for the Association to deal with critical issues with a strategic rather than a tactical approach. In addition, there were references to the desirability of the development of "strategic plan." These sentiments apparently underlying the resolution seemed, to some extent, to grow out of the Management Advancement Program Seminars development of the concept of Strategic Planning as a management process. Consequently the paper included a recapitulatin of the essential elements of the strategic planning process, provided a brief explanation of the elements and by means of an illustration, demonstrated their applicability in the context of the AAMC and its relationship to health related issues.

In short, strategic planning involves a series of steps:

1. The development of a position with respect to the issue or question;

2. The establishment of goals and objectives, which would, if accomplished, resolve the issue in the desired manner;

3. The development of a plan for achieving the objectives.

4. The allocation of resources to carry out the plan.

5. The establishment of decision rules for the guidance of the person responsible for implementing parts of the plan.

6. Providing a feedback loop to correct the previous steps on the basis of after acquired knowledge.

The issues set forth in the Yellow Books provide the questions on which positions could be taken by the AAMC or some component of it, thus accomplishing the first of the steps in strategic planning. It was noted that the issues

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are in different stages of development in terms of the background work done by the AAMC and fall into several categories with respect to their relevance, i.e. some are appropriately dealt with at the institutional level, some at the inter-institutional or Association level, some perhaps by one or another component of the Association, and others by some supra or inter-association group.

The question before the Board at this meeting then, was what should the Board advise the Executive Council. Should the COD Resolution be presented without comment or should the Board present a plan for its implementation?

Dr. Cooper mentioned that he had been in contact with two foundations regarding the possibility of their funding a large national Commission to develop a recommended national health care services policy. One expressed some interest, the other responded that it did not appear that the time was right for such a study and that it probably would not have much impact at the present.

The discussion then addressed the question of the scope of the undertaking being contemplated. The views ranged from an advocacy of the effort to stimulate the articulation of the broadest kind of national health policy (which would provide the framework for directing the Association's energies) on the one hand, to the advocacy of an effort which would seek to define the role of the AAMC with respect to influencing appropriate resolution of the issues raised. On the one hand, it was argued that until there were national policies it would be impossible to know what the medical schools' and thus the Association's role should be. On the other hand, the view was propounded that there would be merit in articulating the Association's view of what the future should hold and setting out an action plan to achieve it.

It was pointed out that on each of the yellow book issues that were relevant to the Association, substantial work had been done. The Bicentennial Anniversary Program for the Expansion of Medical Education (The Cooper-Howard Report) addressed the issue of the number of medical students; the financing issues fell within the purview of the Committee on Financing Medical Education already at work for two years on the related matter of costs; the matter of determinations of quality of education and health services is being addressed by the accreditation mechanisms

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currently being expanded and strengthened, and by the Subcommittee on the Quality of Care of the Health Services Advisory Committee.

Dr. Cooper pointed out that the yellow book was originally developed as a background paper for Secretary Weinberger. The questions remained unanswered because the purpose of raising them was to focus the Secretary's attention on them, not to provide the Association's views which might be disregarded as self serving.

It was suggested that one stimulus to the adoption of the resolution was the COD's incomplete perception of the role being played by the AAMC in policy setting and in addressing the issues raised in the background paper. Thus one aspect of the problem might be a communications gap.

The concern was expressed that there may be insufficient attention to integrating the Association's diverse efforts. In response, it was suggested that this function was performed on two levels: the staff, particularly the executive staff of the Association; and the Executive Council. Another view was that the Executive Council had not the time to devote to this function of active planning and that its role was properly one of reacting to rather fully developed proposals brought to it; the staff was performing admirably in ascertaining areas of concern to the Association, in developing appropriate committees to deal with the issues, and providing the necessary support. Nevertheless, there was no constituency group looking at the big picture in a way which would actively plan in an integrated, wholistic fashion.

This view stimulated the skepticism of some members regarding the efficacy of "blue prints" or five year plans, which traditionally gather dust as affected parties negotiate toward a consensus, or deal with manageable portions of problems on an evolving, although piecemeal basis. Two dangers of large scale efforts were pointed out: 1) They do nothing, expending vast sums to discover the wheel or list platitudes, 2) They make progress in the wrong direction; well meaning observers without an understanding of the underlying problems produce blueprints for disaster.

It was suggested that,impressions aside, the Association was working on the right issues and making progress in determining appropriate positions on the issues, and through various means, hard at work in influencing policy development. In terms of the formal "strategic planning" process

set out, more than position statements may be called for, e.g. the establishment of goals, the development of strategy, mechanisms for evaluation and feedback. Nevertheless, the crucial issue seemed to be that the constituency was unaware of the scope and magnitude of the Association's effort. This may have resulted from the fact that the "yellow book" contained no answers to the questions it posed, leaving the impression that the Association had no positions, and was not dealing adequately with the problems.

The remedy suggested, viewed as a partial approach by some, but acceptable to all as an appropriate undertaking, was that the yellow book be revised and reissued, to include a prologue setting it in context and responses to the question raised. After some further discussion, the Board unanimously adopted the following resolution:

> "That the Administrative Board transmit the Council of Deans resolution to the Executive Council with the recommendation that it direct the staff to prepare a new document setting forth a summary of where the AAMC stands on major issues facing the nation in the areas of medical education, biomedical research, delivery of health services, and the financing of these activities, some of which are identified in the 'Yellow Book', Medical Education: The Institutions, Characteristics and Programs. Such a document, to be periodically updated, should clearly set out the status of the AAMC's efforts in the areas of a) policy formulation, and b) progress toward identified goals, with respect to each of the issues identified."

V. Report of the AAMC Committee on Financing Medical Education

Dr. Cooper began the discussion of this item (Listed as item X of the agenda) with a description of a plan for releasing the report providing it received Executive Council approval. The version that the Board members had was currently undergoing editing by the Director of Publications. No substantive changes would be made, but attention would be paid to grammar and clarity of expression. After approval this version would be retyped and 2,000 copies made. These would be distributed to each medical school, the academic societies, the teaching hospitals and the Congress. A press conference to be held on July 5 would kick-off a nation publicity campaign to be coordinated with the public relations officers. Finally, it would be printed in the October issue of the Journal of Medical Education so

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that it would be indexed and referenced.

He pointed out that the report deals with costs only; the report on financing will be the next task of the committee and is scheduled for completion by December 1973.

Dr. Cooper urged the Board to treat the report as confidential at this time in order that local and national coverage could be simultaneous and coordinated.

Two points of criticism had already been received: that the report makes no attempt to address the issue of quality or to explain why schools should differ so markedly except in terms of a general defense of diversity; and second, that the report comes across as too defensive. The Board was asked to comment on these criticisms, express any others they might have, and offer suggestions regarding possible improvements.

The Board members indicated generally that they had had insufficient time to give the report an adequate review. The criticisms already mentioned were shared as concerns of the Board. There was substantial concern that the report would be greeted by politicians with directives to bring down the expenses in the high cost institutions unless there were convincing justifications in terms of differences in output. Several such measures of output differences were suggested: percent of graduates who were Board Certified, percent of graduates with faculty appointments.

Other concerns expressed included the failure to take note of regional differences in the cost of living and the impact of inflation. With respect to this latter point, it was noted that all costs were expressed in 1972 dollars.

While there was some reservation about the wisdom of releasing the report in advance of the IOM study, the Board declined to take a formal position in opposition to the release of the report at this time. The consensus was that the report appeared to be generally acceptable and that individual board members would state their reservations and suggestions at the Executive Council meeting.

Joint COD-CAS Administrative Boards Luncheon

At this point in the meeting the Board adjourned for a luncheon meeting and discussion with Robert Stone, M.D., Director of the National Institutes of Health. The meeting was informal and off the record. Dr. Stone addressed such issues as the future of training grants and peer review.

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VI. A Procedure for Monitoring The National Intern and Resident Matching Program

After lunch, Mr. Elliott Ray, a member of the OSR Administrative Board, joined the Board to discuss the recent and planned activities of the OSR. Chief among their concerns was the continuing violation of the NIRMP procedures. Several regional meetings had been devoted to developing a monitoring procedure for bringing to light and remedying such violations. This proposal had been considered by the OSR Board and several meetings of the GSA.

After some discussion which included expressions of concern that the requirement for anonymity might prove the undoing of the procedure, the Board agreed to endorse the following proposal:

"On recommendation of the OSR Administrative Board, the COD Administrative Board recommends that the AAMC Executive Council take the following action:

1. Recommend that each medical school establish a committee to review reports of non-compliance with NIRMP procedures consisting of at least the following members:

    a. the school's OSR representative

    b. the Dean of Student Affairs or some other GSA representative

    c. a faculty member from one of the clinical departments appointed by the dean.

2. Recommend that each medical school include in its student orientation to the NIRMP a discussion conducted by this committee of the importance of working within the established procedures; that the students be requested to report violations to any member of this committee,

3. Request that the AMA include in its directory of approved internships and residencies a brief form to be developed by the OSR (in consultation with the AAMC staff) for reporting NIRMP code violations,

4. Recommend that each medical school include within its packet of material distributed on the NIRMP and have available in the office of the dean copies of such violations reporting forms.

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5. Recommend that the procedures under which the schools' NIRMP review committee operates should include the following:

   a. provide a guarantee of anonymity to complaining students;

   b. assume responsibility for securing all pertinent data regarding alleged violation;

   c. grant permission for any committee member to request a meeting of the committee to determine whether data submitted merits follow-up;

   d. where it is agreed that a violation exists and the program in question does not intend to abide by its contract agreements, the committee will, 1) advise the dean, and 2) report the violation to the National NIRMP monitor.

6. Recommend that the student member of the NIRMP Board be designated as the OSR National NIRMP Monitor, whose duties shall be to, a) receive the reports of the schools of violations of the NIRMP procedures, b) send a report of such violations to the NIRMP Board of Directors and to the AAMC Executive Council, c) make an annual report to the Organization of Student Representatives at its annual meetings on reports to the NIRMP Board of Directors and the AAMC Executive Council and the action taken by the NIRMP on each violation."

Several Board members commented that this proposal is a very constructive response of the students to the problem, and expressed the view that the proposal would be very helpful to the institutions' efforts to protect the student's interests.

VII. Senior Members

At this point, Dr. Mellinkoff introduced an item not on the agenda. He related several informal discussions in which he had participated focussing on a concern that the Association should develop some mechanism to foster the continuing participation of men such as Dr. Stone, Dr. Marston and Dr. Anlyan, who had contributed much to the Association, but who by reason of their present position no longer had a formal relationship to the AAMC. The suggestion had been made that the category of Senior

Members in the AAMC be enhanced to provide an attractive vehicle for such continued participation. This might be accomplished by appropriate Bylaw changes to provide each such member the privilege of the floor in any meeting of the Council of which he had previously been a member, and adding a seat on the Executive Council to be filled by a Senior Member elected by his collegues of that status.

Dr. Mellinkoff solicited the reaction of the Board to this proposal. The Board concurred that this appeared to be a desirable course of action. Dr. Mellinkoff indicated that he proposed to request that the Executive Council request the staff to examine the matter and to present appropriate Bylaw provisions for consideration at the next meeting.

VIII <u>AAMC Policy Statement--The Patient in the Teaching Setting</u>

The staff had prepared a proposed statement relating to the rights of patients in the teaching setting. The APHA had adopted a resolution urging the AAMC and others to make such a statement. Dr. Cooper indicated that having the Association on record on such a matter would strengthen our position in forthcoming hearings on medical ethics to be held in the Senate, and would be of potential assistance in negotiations relating to H.R.1.

There were reservations relating to the potential this might have for creating additional liability for member institutions beset by litigious patients and house staff in the event that they were unable to comply completely with the standards set out.

After some discussion which included assurances that the Association's Policy was a general statement of principle which exhorted the institutions to achieve an ethical standard, but was in no way legally binding in its members, the Board endorsed Executive Council adoption of the following:

> "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 provided not only 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.

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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."

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IX. Review of the Closeout of the Freestanding Internship

This matter was brought to the Board by Dr. Buchanan whose concerns were stimulated by several recent events: the increase in the number of Cornell graduates unmatched by the NIRMP; the requirement of many specialty residency programs of a year of "mixed" or rotating internships as preparation for entry; the rigidity of the requirements for the approval of Family Practice residencies which appear to threaten well-established mixed internships where such a residency would appear to solve the problem; the demise of the NIH support for clinical fellowships which will tend to increase the demand for residency openings.

The Board voted to request the Executive Council to direct the AAMC staff to undertake an examination of the availability of appropriate post-doctoral clinical training opportunities for the increasing numbers of graduates of medical schools over the next several years.

Such an examination should explore the phenomenon of the increasing number of graduates unmatched through the NIRMP and the impact of the phase-out of the free-standing internship. This matter should also be brought to the attention of other appropriate bodies, such as the coordinating Council of Medical Education. An assessment of the situation and recommendations for influencing its redress should be presented in a time-span which would permit appropriate remedial action.

X. Moonlighting House Officers

Dr. Mellinkoff raised the issue of the compatibility of moonlighting with the educational objectives of house officer programs. He noted that the amount of money earned by some cast serious doubt on the availability of time and energy devoted to educational pursuits.

The Board requested that staff examine the issue and the availability of devices to control the practice of moonlighting. Such an examination should include the legal implication of the adoption of any approach. Approaches suggested included surveillance of residency and intern programs thru accreditation standards and review and making a prohibition of the practice a standard term in the house officers contract.

The following resolution was adopted:

"The Board considered the matter of moonlighting house officers and the potentially deleterious

impact of this practice on the quality of graduate medical education. The staff was requested to examine the nature and extent of this perceived problem and to report back to the Board on potential methods to curtail this practice, including an analysis of the legal and other consequences of proposed methods."

XI. Annual Meeting Agenda Items

In addition to the previously considered COD Business Meeting agenda items, the Board received two requests for meeting time at the annual meeting.

The first was from the Veteran's Administration suggesting that a joint meeting be held in a similar format to last year's meeting. After some discussion, the Board agreed to a meeting on Monday, November 5, after the COD Business Meeting and set out the following guidelines for the meeting:

1. There should be no formal presentations; the format should provide for an open forum in which a panel consisting of the Chief Medical Director and members of his staff would respond to questions from the floor.

2. Any material the VA wanted to disseminate in a formal way should be in written form and distributed in advance of the meeting, preferrably with the agenda material, or at the latest, with the meeting registration materials.

3. Dr. Mellinkoff should chair the meeting.

The second item was a suggestion from John Millis, President of the National Fund for Medical Education, that he appear to explain briefly "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 being initiated" to obtain access to mass media. The Board agreed that it would be appropriate to devote approximately 10 minutes of the COD Business Meeting to this topic.

XII. Adjournment

The meeting was adjourned at 3:45 p.m.

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Attachment 1

Notes on the Regional Medical Library Program

The Regional Medical Library Program is in the process of an evaluation through site visits to each of the regional medical libraries. While just over half of the regional medical libraries have been visited, several important points have recurrently emerged which we believe need to be brought to the attention of the administrative authorities of the institutions of which these libraries are a part.

1. The development of the RMLP is a steppingstone in the evolution of a national biomedical communications network involving commitments by participating institutions which include service to the community, sharing of resources, and giving up some degree of institutional autonomy. Since all of these are essentially traditional among libraries and librarians, they (the librarians) are making these commitments with alacrity. However, NLM and its consultants are concerned that the administrative heads of these institutions may not be aware or fully appreciate that such commitments are being made.

2. This network is already well developed in many parts of the country, and could be a critical and important resource in various programs, such as, continuing education, area health education centers, PSRO, etc. They have, however, been little recognized and even less utilized by the medical profession or by the institutions housing these libraries which have active programs of this nature. Indeed, in one region we recently held a meeting of the librarians and the directors of continuing education. We almost had to introduce members of the same institution to each other let alone introduce each to the problems and programs of the others.

3. The evaluation committee of NLM has been concerned about the acceptance and exploitation of this network in terms of the rational operation and development of library services throughout the country. Most medical school libraries are still operating in a traditional fashion with a great emphasis on the archival involvment of the library, while at the same time complaining bitterly about rising costs of supporting such a library. The presence of this network allows the opportunity for the conversion of medical libraries to functional activities concerned fundamentally with distribution of information rather than its storage. There is little indication that any of the medical schools in the country are attempting to take advantage of this network in order to more effectively utilize funds for library services through such things as coordinated acquisition programs and reliance on the network for the delivery of little used material.

4. We believe that further progress in the RMLP and the development of a national biomedical communications network requires an institutional commitment and utilization of resources beyond those of the library.

For all of these reasons, the NLM--strongly urged by its advisers--would like to establish a mechanism for informing more completely the deans of the medical schools about this program and its potentialities. We hope to solicit the deans' support in the pursuit of these objectives.

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The Sprague Committee Report: "Undergraduate Medical Education: Elements--Objectives--Costs."

Comments by members of the three administrative boards which were received as well as comments from Rashi Fein, Adam Yarmolinski, and John Millis, will be accommodated in so far as possible in a revision of the report which is being prepared. This draft will be distributed as soon as it is completed.

The joint meeting of the three boards to be held at 6:30 p.m. September 12, 1973, at the Dupont Plaza Hotel will be devoted to a review of this version of the report.

The COD Administrative Board will have additional opportunity to comment on the report at its September 13, 1973 meeting in advance of anticipated Executive Council action on September 14.

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REPRESENTATION IN THE AAMC ASSEMBLY

The AAMC Assembly presently consists of all U.S. members of the Council of Deans (114), 35 designated representatives of the Council of Academic Societies, 35 designated representatives of the Council of Teaching Hospitals, and ten (10) percent of the members of the Organization of Student Representatives (11). The Association Bylaws further indicate that all other members shall have the privileges of the floor without vote.

Since the adoption of this formula for Assembly representation, the voting membership of the COD has expanded with the addition of new medical schools, while the representation of both CAS and COTH has remained fixed. At the most recent meeting of the CAS Administrative Board this pattern of representation was questioned.

At its meeting on June 21, 1973 the CAS Administrative Board adopted a motion requesting that CAS representation in the Assembly be increased to reflect one vote for each constituent society, not to exceed the representation of the COD. The Association's Executive Council discussed this issue at its meeting on the following day and requested that each Administrative Board at its next meeting reassess the pattern of representation in the Assembly. Recommendations of the Administrative Boards are to be forwarded to the Executive Council for consideration at its September 14 meeting.

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SENIOR MEMBERSHIP IN THE AAMC

At the June meeting of the Council of Deans Administrative Board, the AAMC staff was asked to explore the possibility of utilizing the Senior membership category to provide continued participation of individuals once active in the Association who no longer are members of any Council. The Executive Council, meeting the following day, considered this matter and approved a motion to:

1. direct the staff to prepare a proposal based on the recommendations discussed;
2. place this item on the agenda of the three administrative boards at their September meetings.

In accordance with the Executive Council directive, AAMC staff has developed the following Guidelines:

1. Senior members shall henceforth be called Distinguished Members.
2. Distinguished Members shall be elected by the Assembly on recommendation of the Executive Council and one of the constituent Councils.
3. The principal criterion for selection of Distinguished Members shall be active and meritorious participation in AAMC affairs while a member of one of the AAMC Councils. Additional criteria may be established by the Executive Council or constituent Councils responsible for nominating Distinguished Members.
4. Each Distinguished Member shall have honorary membership status on the Council which recommended his/her election, i.e., he/she would be invited to all meetings and would have the privileges of the floor without vote.
5. Distinguished Members shall meet as a group once a year at the Annual Meeting and elect a Chairman and/or Chairman-Elect.
6. Distinguished Members shall be eligible for Emeritus Membership at age 65; Emeritus Membership would be mandatory at age 70.
7. AAMC Bylaws shall be modified to incorporate these changes and to provide Distinguished Members with voting representation on the Executive Council through a 21st member of that Council. This position shall be filled by the Chairman of the Distinguished Members.

Bylaws changes necessary to meet the requirements listed above are under review by the Association's legal counsel and will be available for consideration by the September meetings. A copy of the current AAMC Bylaws appears on the following pages.

RECOMMENDATION

It is recommended that the Executive Council:

1. recommend to the Assembly approval of the Bylaws revisions proposed;

2. approve the proposed Guidelines for Distinguished Membership, to become effective if the Assembly approves the necessary Bylaws revisions.

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PROPOSED AAMC BYLAWS REVISIONS

1. Title I, Section 2, Paragraph B:

   Delete the existing paragraph B and insert:

   B. Distinguished Members - Distinguished Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.

2. Title I, Section 3

   Add Paragraph E:

   E. Distinguished members will be recommended to the Executive Council by the Administrative Board of either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.

3. Title VI, Section 2

   The Executive Council shall consist of fourteen members elected by the Assembly and ex officio, the Chairman, Chairman-Elect, President, the Chairman of each of the three councils created by these bylaws, and the Chairman of the Organization of Student Representatives, all of whom shall be voting members. Of the fourteen members of the Executive Council elected by the Assembly, three shall be members of the Council of Academic Societies; two shall be members of the Council of Teaching Hospitals; eight shall be members of the Council of Deans, and one shall be a Distinguished Member. The elected members of the Executive Council shall be elected by the Assembly at its annual meeting, each to serve for three years (except for the Distinguished Member who shall serve for one year) or until the election and installation of his successor. Each shall be eligible for reelection for one additional consecutive term of three years. Each shall be elected by majority vote and may be removed by a vote of two-thirds of the members of the Assembly present and voting.

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ARTICLES OF INCORPORATION OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Under the Illinois General Not for Profit Corporation Act

1. The name of the corporation is Association of American Medical Colleges.

2. The period of duration of the corporation is perpetual.

3. The address of its registered office in the State of Illinois is 135 South LaSalle Street, Chicago, Illinois. The name of its registered office in the District of Columbia is One Dupont Circle, Washington, D.C. The name of its registered agent at said address is James W. Quiggle.

4. [Names of initial Board of Directors omitted.]

5. The purpose for which the corporation is organized is the advancement of medical education. The purpose is exclusively educational, scientific, and charitable. Any net earnings of the corporation or of any of its activities shall be devoted exclusively to such purpose and shall not inure to the benefit of any individual. There shall be no shareholders of the corporation.

6. The Board of Directors shall be known as the Executive Council, and the directors shall be called Executive Council Members. The Executive Council shall have the complete direction and control of the property and affairs of the corporation, and the acts of the Executive Council shall be the acts of the corporation for all purposes.

7. The membership of the corporation shall consist of classes known as Institutional Members, Provisional Institutional Members, Academic Society Members, and Teaching Hospital Members, and such other members as shall be provided in the Bylaws. Institutional Members shall have the right to vote. Provisional Institutional Members, Academic Society Members, and Teaching Hospital Members shall have the right to vote to the extent and in the manner provided in the Bylaws. Other classes of members shall have no right to vote and no action of theirs shall be necessary for any corporate action. The membership of all classes shall consist of such persons as may from time to time be designated pursuant to the Bylaws.

8. In the event of dissolution of the corporation, all of its assets (after payment of, or provision for, all its liabilities) shall be transferred or conveyed to one or more domestic or foreign corporations, societies, or organizations engaged in activities substantially similar to those of the corporation, to be used by them for the purpose set forth in Article 5.

9. Provided, however, the purposes stated in Article 5 shall not be deemed to authorize the corporation to receive any child for care or placement apart from its own parent or guardian, nor shall the corporation act as or perform any of the functions of a post-secondary or vocational institution.*

*This sentence has been inserted to avoid any question of compliance or noncompliance with certain Illinois legal requirements.

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BYLAWS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

I. MEMBERSHIP

Section 1. There shall be the following classes of members, each of which that has the right to vote shall be (a) an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal tax laws), and (b) an organization described in Section 509 (a) (1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal tax laws), and each of which shall also meet (c) the qualifications set forth in the Articles of Incorporation and these Bylaws, and (d) other criteria established by the Executive Council for each class of membership:

A. Institutional Members - Institutional Members shall be medical schools and colleges of the United States.

B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.

C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.

D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges of the United States.

E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.

F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.

G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional fields of medicine and biomedical sciences.

H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.

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Section 2. There shall also be the following classes of honorary members who shall meet the criteria therefore established by the Executive Council:

A. Emeritus Members - Emeritus Members shall be those retired individuals who have been active in the affairs of the Association prior to retirement.

B. Senior Members - Senior Members shall be persons who have been actively involved in the affiars of the Association and who have been appointed to university or institutional administrative positions with broad responsibilities related to academic health centers.

C. Individual Members - Individual Members shall be persons who have demonstrated a serious interest in medical education.

D. Sustaining and Contributing Members - Sustaining and Contributing Members shall be persons or corporation who have demonstrated over a period of years a serious interest in medical education.

Section 3. Election to membership:

A. All classes of members shall be elected by the Assembly by a majority vote on recommendation of the Executive Council.

B. All institutional members will be recommended by the Council of Deans to the Executive Council.

C. Academic society members will be recommended by the Council of Academic Societies to the Executive Council.

D. Teaching hospital members will be recommended by COTH to the Executive Council.

Section 4. Revocation of Membership - A member with any class of membership may have his membership revoked by a two-thirds affirmative vote of the Assembly on recommendation with justification by the Executive Council; provided that the Executive Council shall have given the members written notice of the proposed revocation prior to the Assembly at which such a vote is taken.

Section 5. Resignation - A member with any class of membership may resign upon notice given in writing to the Executive Council. However, any such resignation shall not be effective until the end of the fiscal year in which it is given.

II. COUNCILS

Section 1. There shall be the following Councils of the Association each of which shall be governed by an Administrative Board and each of which shall be organized and operated in a manner consistent with rules and regulations approved by the Executive Council:

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A. Council of Deans - The Council of Deans shall consist of the Dean or the equivalent academic officer of each institutional member and each provisional institutional member that has admitted its first class of students.

B. Council of Academic Societies - The Council of Academic Societies shall consist of two representatives from each academic society member who shall be designated by each such member for a term of two years.

C. Council of Teaching Hospitals - The Council of Teaching Hospitals shall consist of one representative from each teaching hospital member who shall be designated annually by each such member.

III. ORGANIZATION OF STUDENT REPRESENTATIVES

There shall be an Organization of Student Representatives related to the Council of Deans, operated in a manner consistent with rules and regulations approved by the Council of Deans and comprised of one representative of each institutional member that is a member of the Council of Deans chosen from the student body of each such member. The Organization of Student Representatives shall meet at least once each year at the time and place of the annual meeting of the Council of Deans in conjunction with said meeting to elect a Chairman and other officers, to recommend student members of committees of the Association, to recommend to the Council of Deans the Organization's representatives to the Assembly, and to consider other matters of particular interest to students of institutional members. All actions taken and recommendations made by the Organization of Student Representatives shall be reported to the Chairman of the Council of Deans.

IV. MEETINGS OF MEMBERS AND COUNCILS

Section 1. Meetings of members of the Assocation shall be known as the Assembly. An annual Assembly shall be held at such time in each October or November and at such place as the Executive Council may designate.

Section 2. Special meetings of the Assembly may be called for any purpose by the Chairman, by a majority of the voting members of the Executive Council, or by twenty voting members of the Association.

Section 3. All meetings of the Assembly shall be held at such place in Illinois, the District of Columbia or elsewhere as may be designated in the notice of the meeting. Written or printed notice stating the place, day and hour of the meeting and, in case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not less than

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five nor more than forty days before the date of the meeting, either personally or by mail, by or at the direction of the Chairman or persons calling the meeting, to each member entitled to vote at such meeting.

Section 4. The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the Council of Deans and a number of members of the Organization of Student Representatives equivalent to 10 percent of the members of the Association having representatives in said Organization. Each of such representatives of Institutional Members and Provisional Institutional Members that have admitted their first class shall have the privilege of the floor in all discussions and shall be entitled to vote at all meetings. The Council of Academic Societies and the Council of Teaching Hospitals each shall designate no more than thirty-five of their respective members as members of the Assembly, each one of whom shall have one vote in the Assembly. All other members shall have the privileges of the floor in all discussions but shall not be entitled to vote at any meeting.

Section 5. A representative of each voting member shall cast its vote. The Chairman may accept the written statement of the Dean of an institutional member, or provisional institutional member, that he or some other person has been properly designated to vote on behalf of the institution, and may accept the written statement of the respective Chairmen of the Council of Academic Societies and the Council of Teaching Hospitals designating the names of individuals who will vote on behalf of each member society or hospital. The Chairman may accept the written statement of the Chairman of the Council of Deans reporting the names of the individuals who will vote as the representatives chosen by the Organization of Student Representatives.

Section 6. One-third of the voting members of the Association shall constitute a quorum at the Assembly. Except as otherwise provided herein, action at any meeting shall be by majority vote at a meeting at which a quorum is present, provided that if less than a quorum be present at any meeting, a majority of those present may adjourn the meeting from time to time without further notice.

Section 7. Each Council of the Association shall meet at least once each year at such time and place as shall be determined by its bylaws and designated in the notice thereof for the purpose of electing members of the Administrative Board and officers.

Section 8. Regional meetings of each Council may be held in each of the geographical regions established by the Executive Council for the purpose of identifying, defining and discussing issues relating to medical education and in order to make recommendations for further action at the national level. Such meetings of each Council shall be held at such time and place as determined in accordance with procedures approved by the Executive Council.

Section 9. No action of the Association shall be construed as committing any member to the Association's position on any issue.

Section 10. Robert's Rules of Order, latest edition, shall govern all meetings.

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V. OFFICERS

The officers of the Association shall be those elected by the Assembly and those appointed by the Executive Council.

Section 1. The elected officers shall be a Chairman, who shall preside over the Assembly and shall serve as Chairman of the Executive Council, and a Chairman-Elect, who shall serve as Chairman in the absence of the Chairman. The Chairman-Elect shall be elected at the annual meeting of the Assembly, to serve in that office for one year, and shall then be installed as Chairman for a one-year term in the course of the annual meeting of the Assembly the year after he has been elected. If the Chairman dies, resigns, or for any other reason ceases to act, the Chairman-Elect shall thereby become Chairman and shall serve for the remainder of that term and the next term.

Section 2. The officers appointed by the Executive Council shall be a President, who shall be the Chief Executive Officer, a Vice President, a Secretary and a Treasurer, who shall be appointed from among the Executive Council members. The Executive Council may appoint one or more additional officers on nomination by the President.

Section 3. The elected officers shall have such duties as are implied by their title or are assigned to them by the Assembly. The appointed officers shall have such duties as are implied by their titles or are assigned to them by the Executive Council.

VI. EXECUTIVE COUNCIL

Section 1. The Executive Council is the Board of Directors of the Association and shall manage its affairs. The Executive Council shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law and the Bylaws. It shall carry out the policies established at the meetings of the Assembly and take necessary interim action for the Association and carry out duties and functions delegated to it by the Assembly. It shall set educational standards and criteria as prerequisites for the election of members of the Association, it shall consider applications for membership and it shall report its findings and recommendations with respect thereto to the Assembly.

Section 2. The Executive Council shall consist of thirteen members elected by the Assembly and ex officio, the Chairman, Chairman-Elect, President, the Chairman of each of the three councils created by these Bylaws, and the Chairman of the Organization of Student Representatives, all of whom shall be voting members. Of the thirteen members of the Executive Council elected by the Assembly, three shall be members of the Council of Academic Societies; two shall be members of the Council of Teaching Hospitals; eight shall be members of the Council of Deans. The elected members of the Executive Council shall be elected by the Assembly at its annual meeting, each to serve for three years or until the election and installation of his successor. Each shall be eligible for reelection for one additional consecutive term of

three years. Each shall be elected by majority vote and may be removed by a vote of two-thirds of the members of the Assembly present and voting.

Section 3. At least one elected member of the Executive Council shall be from each of the regions of the Association.

Section 4. The annual meeting of the Executive Council shall be held within eight (8) weeks after the annual meeting of the Assembly at such time and place as the Chairman shall determine.

Section 5. Special meetings of the Council may be called by the Chairman or any two (2) Council members, and written notice of all Council meetings, unless waived, shall be mailed to each Council member at his home or usual business address not later than the tenth business day before the meeting.

Section 6. A quorum of the Council shall be a majority of the voting Council members.

Section 7. In the event of a vacancy on the Executive Council, the remaining members of the Council may appoint a successor to complete the unexpired term. appointed members may not serve more than two consecutive full terms on the Council following appointment to an unexpired term. The Council is authorized in its own discretion to leave a vacancy unfilled until the next annual meeting of the Assembly.

VII. COMMITTEES

Section 1. The Chairman shall appoint from the Assembly a Resolutions Committee which shall be comprised of at least one representative from each Council of the Association and from the Organization of Student Representatives. The Resolutions Committee shall present resolutions to the Assembly for action by it. No resolution shall be considered for presentation by the Resolutions Committee unless it shall have been received at the principal office of the Association at least fourteen days prior to the meeting at which it is to be considered. Additional resolutions may be considered by the Assembly upon a two-thirds vote of the members of the Assembly present and voting.

Section 2. The Executive Council shall appoint the Chairman and a Nominating Committee of not less than four nor more than six additional members, including the Chairman of the Nominating Committee of each of the Councils provided in Paragraph II. The Nominating Committee so appointed will report to the Assembly at its annual meeting one nominee for each officer and member of the Executive Council to be elected. Additional nominees for any officer or member of the Executive Council may be made by the representative of any member of the Assembly. Election shall be by a majority of the Assembly members present and voting.

Section 3. The Executive Council, by resolution adopted by the vote of a majority of the voting Council members in office, may designate an Executive Committee to act during intervals between meetings of the Council, consisting

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of the Chairman, the Chairman-Elect, the Treasurer, the President, and three or more other Council members, which committee, to the extent provided in the resolution, shall have and exercise the authority of the Council in the management of the Association. At all times the Executive Committee shall include at least one member of each of the Councils provided in Paragraph II hereof. The designation of such a committee and the delegation to it of authority shall not relieve the Council, or any members of the Council, of any responsibility imposed upon them by law.

Section 4. The Executive Council may appoint and dissolve from time to time such standing or ad hoc committees as it deems advisable, and each committee shall exercise such powers and perform such duties as may be conferred upon it by the Executive Council subject to its continuing direction and control. The Chairman will appoint members of the committees with appropriate consultation with the Executive Council.

VIII. GENERAL PROVISIONS

Section 1. Whenever any notice whatever is required to be given under the provisions of these Bylaws, a waiver thereof in writing signed by the persons entitled to such a notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

Section 2. The Council may adopt a seal for the Association, but no seal shall be necessary to take or to evidence any Association action.

Section 3. The fiscal year of the Association shall be from each July 1 to June 30.

Section 4. The annual dues of each class of members shall be in such amounts as shall be recommended by the Executive Council and established by the Assembly. The Executive Council shall consult with the respective administrative boards of the Council of Deans, the Council of Academic Societies and the Council of Teaching Hospitals in arriving at its recommendations.

Section 5. Any action that may be taken at a meeting of members or of the Executive Council may be taken without a meeting if a consent in writing setting forth the action so taken is signed by all members of the Association entitled to vote with respect to the subject matter thereof, or by all members of the Executive Council as the case may be.

Section 6. No part of the net earnings of the Association shall inure to the benefit of or be distributable to its members or members of the Executive Council, officers, or private individuals, except that the Association may pay reasonable compensation for services rendered and make payment and distributions in furtherance of its purposes. No

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substantial part of the activities of the corporation shall be the carrying on of propaganda or otherwise attempting to influence legislation, and the Association shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of these articles, the Association shall not carry on any activities not permitted to be carried on (a) by an organization exempt from Federal income tax under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or (b) by an organization, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

Section 7. Upon dissolution of the corporation, the Executive Council shall, after paying or making provision for the payment of all of the liabilities of the Association (including provision of a reasonable separation pay for its employees), dispose of all of the assets of the Association among such non-profit organizations having similar aims and objects as shall qualify as exempt organiztions described in Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provisions of any future United States Internal Revenue Law.)

Section 8. These Bylaws may be amended by a two-thirds vote of the voting members present and voting at any duly called meeting of the Assembly, provided that the substance of the proposed amendment is included with the notice of the meeting. Amendments to the Bylaws may be proposed by the Executive Council or by the written sponsorship of ten voting members, provided that the proposed amendment shall have been received by the Secretary at least forty-five days prior to the meeting at which it is to be considered.

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PROPOSED AAMC BYLAWS REVISIONS

1. Some change may be necessary in Article 7 of the Articles of Incorporation. Is this subject to change? Does the single vote on the Executive Council justify or require any modification of the statement, "Other classes of members shall have no right to vote and no action of theirs shall be necessary for any corporate action?"

2. Title I, Section 2, Paragraph B:

   Delete the existing paragraph B and insert:

   B. Distinguished Members - Distinguished Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.

3. Title I, Section 3

   Add Paragraph E:

   E. Distinguished members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.

4. Title VI, Section 2

   Add the words, "and the Chairman of the Distinguished Members," on line 4 after the word, "Representatives".

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Graduate Affiliate Institutional Membership

William R. Willard, M.D., Dean of the College of Community Health Services, The University of Alabama at Tuscaloosa, and G. Gayle Stephens, M.D., Dean of the School of Primary Medical Care, The University of Alabama, have written seeking some form of institutional membership in the AAMC. In response, Dr. Cooper has indicated that "it would appear that there is no category of membership appropriate for these institutions. In return, Dr. Willard has suggested that since the major program element will be a family practice residency, affiliated with the University at Birmingham, his institution would seem to be eligible as a Provisional Graduate Affiliate Institutional Member.

This class of institutional membership in the AAMC is provided for in the Association Bylaws:

Paragraph I Membership, Section 1, subsection C, which reads as follows: "Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members."

At present there is only one institution with this category of Association Membership:

Charles R. Drew
Postgraduate Medical School

This institution is described in the AAMC Directory of American Medical Education as follows:

> "The Charles R. Drew Postgraduate Medical School is the academic center for the Los Angeles County-Martin Luther King, Jr. General Hospital, which opened in March 1972. The Drew School was founded by the UCLA and USC Schools of Medicine and the Charles R. Drew Medical Society (Los Angeles chapter, National Medical Association) in 1966. Each of its 11 departments is affiliated with either UCLA or USC Schools of Medicine.
>
> The Drew School is providing professional training for graduate physicians and dentists and education and training in the allied health professions. An active continuing education program for community health workers, opportunities for clinical rotation to and from UCLA and USC, and planning a rational health services network for South Central Los Angeles are further tasks."

Prior to the establishment of a program in undergraduate medical education at the institution, Mayo Graduate School of Medicine was also a Graduate Affiliate Institutional Member (until the end of the academic year 1971-1972). The discriptive material in the Directory for that year reads as follows:

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"The Mayo Graduate School of Medicine has been part of the University of Minnesota since 1915. It conducts an educational program in which, under the auspices of the Mayo Foundation, the graduate student may elect to combine residency training in a clinical field with a program leading to the M.S. or Ph.D. degree."

Since the Association's original response to these institutions did not contemplate the possibility of membership in the category of Graduate Affiliate Institutional Members, it is appropriate that this matter be examined more fully. It is being referred to the COD Administrative Board for its consideration of the advantages to the institutions and the advantages to the AAMC.

Election to any category of institutional membership requires a recommendation by the Council of Deans to the Executive Council, from the Executive Council to the Assembly, and favorable action by the Assembly.

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JUN 18 1973

THE UNIVERSITY OF ALABAMA
POST OFFICE BOX 6291
UNIVERSITY, ALABAMA 35486

COLLEGE OF COMMUNITY HEALTH SCIENCES

TELEPHONE: 205/348-7942

June 7, 1973

John Cooper, M. D.
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear John:

I am wondering whether The University of Alabama at Tuscaloosa is eligible for institutional membership in the AAMC, and if so, what the dues would be. We have a peculiar situation in Alabama, as perhaps you know. The University of Alabama has three campuses: Birmingham, where the Medical School is located; Huntsville; and Tuscaloosa, which is the historic headquarters of The University. Although the three campuses are under the government of a single Board of Trustees, each operates autonomously, for the most part. Both Tuscaloosa and Huntsville will have Medical Education Programs featuring Family Practice Residencies but providing some undergraduate clerkship experience in cooperation with the Medical School at Birmingham. We will not have independent medical schools in the classical sense, at least for the foreseeable future.

If there is a classification such as "Associate Membership", under which we would qualify, I believe that we should make application. However, it may be that our representation should come through the Medical School at Birmingham. In any event, I would like your advice, and should we be eligible, I would like to know what the institutional dues would be.

Best personal wishes.

Yours sincerely,

Bill

William R. Willard, M. D.
Dean

WRW:cw

THE UNIVERSITY OF ALABAMA
POST OFFICE BOX 6291
UNIVERSITY, ALABAMA 35486

COLLEGE OF COMMUNITY HEALTH SCIENCES

TELEPHONE: 205/348-7942

July 10, 1973

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

Dear John:

Thank you for your letter of June 19 giving me your view that presently there is no category of membership appropriate for the Tuscaloosa campus of The University of Alabama.

As I read the Bylaws of the AAMC, which you included, we thought that Section 1, Paragraph F, might provide a basis for our membership. Since the major, but not the only, program element would be a family practice residency affiliated with The University of Alabama at Birmingham, this would seem to make us eligible under the heading Provisional Graduate Affiliate Institutional Members. We would view the residency as graduate education, although maybe the intent was to cover some other type of instituion when the Bylaws were drafted.

I am not trying to create an issue about this matter because our relationships with Birmingham are good. I am only seeking clarification.

Best personal wishes.

Yours sincerely,

William R. Willard, M.D.
Dean

WRW:cw

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June 19, 1973

William R. Willard, M. D.
Dean
The University of Alabama
College of Community Health Sciences
Post Office Box 6291
University, Alabama 35486

Dear Bill:

In response to your letter of June 7, 1973 inquiring as to the eligibility of The University of Alabama at Tuscaloosa for institutional membership in the AAMC, I have examined and am enclosing the Articles of Incorporation and the Bylaws of the Association. It would appear from a close reading of these documents that there is presently no category of membership appropriate for The University of Alabama at Tuscaloosa.

I am gratified that the activities of the AAMC are viewed as sufficiently important to stimulate you to seek membership for your institution. Even though it does not appear possible to work out a direct organizational relationship, I trust that we will be able to provide your institution many of the benefits of membership indirectly through your involvement with the medical school at Birmingham. By maintaining close communications with Dean Pittman at Birmingham, it should be possible for you to keep track of the comings and goings of the AAMC. Please be assured that on specific matters of interest to you, my staff and I stand ready to provide whatever advice and assistance might be helpful.

Warm regards.

Sincerely,

John A. D. Cooper, M. D.

Enclosures

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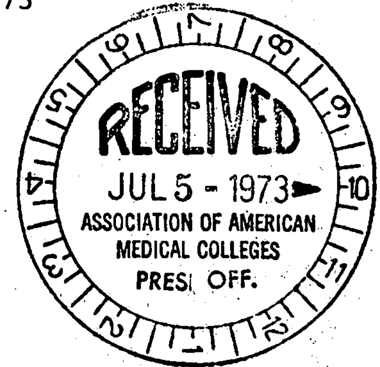
JUL 6 1973

The University Of Alabama In Huntsville

School of Primary Medical Care

P. O. Box 1247
Huntsville, Alabama 35807

July 2, 1973



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

Dear Dr. Cooper:

The University of Alabama System has established a School of Primary Medical Care in affiliation with The University of Alabama in Huntsville and the Medical Center in Birmingham. This school will involve the clinical education of medical students in the primary care disciplines who have completed their basic science experience in Birmingham. It will also develop graduate programs in Family Medicine, Pediatrics, and Internal Medicine.

We would like to make arrangements for an institutional membership in the Association of American Medical Colleges. If membership is not possible, we would at least like to try to get on the mailing list of the AAMC in order to receive your bulletins and publications.

May I hear from you at your convenience.

Sincerely yours,

G. Gayle Stephens, MD
Dean of School of Primary Medical Care

P.S. I have an individual membership in the AAMC which is terminating and I would like to transfer that to the Institution if possible.

GGS/wpc/ab

July 19, 1973

G. Gayle Stephens, M.D.
Dean
School of Primary Medical Care
University of Alabama in Huntsville
P.O. Box 1247
Huntsville, Alabama 35807

Dear Dr. Stephens:

In response to your letter of July 2, 1973 inquiring as to the eligibility of the University of Alabama at Huntsville for institutional membership in the AAMC, I have examined and am enclosing the Articles of Incorporation and the Bylaws of the Association. It would appear from a close reading of these documents that there is presently no category of membership appropriate for the University of Alabama at Huntsville.

I am gratified that the activities of the AAMC are viewed as sufficiently important to stimulate you to seek membership for your institution. Even though it does not appear possible to work out a direct organizational relationship, I trust that we will be able to provide your institution many of the benefits of membership indirectly through your involvement with the medical school at Birmingham. By maintaining close communications with Dean Pittman at Birmingham, it should be possible for you to keep track of the comings and goings of the AAMC. Please be assured that on specific matters of interest to you, my staff and I stand ready to provide whatever advice and assistance might be helpful.

Warm Regards!

Sincerely,

John A. D. Cooper, M.D.

Enclosures

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Election of Institutional Members

The following medical schools have received full accreditation by the Liaison Committee on Medical Education, have graduated a class of students and are eligible for full Institutional Membership in the AAMC:

1. Louisiana State University
   School of Medicine in Shreveport

2. Rush Medical College
   Rush-Presbyterian-St. Luke's Medical Center

3. University of Missouri - Kansas City
   School of Medicine

The following school of the basic medical science has received full accreditation by the Liaison Committee on Medical Education, a class of students has completed its program, and is eligible for full Institutional Membership in the AAMC:

1. University of Nevada, Reno
   School of Medical Sciences

Recommendation: That the COD Administrative Board recommend that Executive Council nominate to the Assembly these institutions for election to Institutional Membership in the AAMC, provided that this action is ratified by the full Council of Deans on November 5, 1973.

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Election of Affiliate Institutional Members

The following medical schools have received full accreditation by the Liaison Committee on Medical Education, have graduated a class of students, and are eligible for election to Affiliate Institutional Membership in the AAMC:

1. Memorial University
   Faculty of Medicine
   St. John's, Newfoundland, Canada

2. University of Calgary
   Faculty of Medicine
   Calgary, Alberta, Canada

Recommendation: That the COD Administrative Board recommend that Executive Council nominate to the Assembly these institutions for election to Affiliate Institutional Member in the AAMC, provided that this action is ratified by the Council of Deans on November 5, 1973.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

August 27, 1973

MEMORANDUM

TO: COD Administrative Board

FROM: Joseph A. Keyes

SUBJECT: COD/VA Joint Program

This is to confirm that the Veterans Administration, in the person of Mr. Ed Friedlander, Special Assistant to the Chief Medical Director, Department of Medicine and Surgery, has agreed to the guidelines for the COD/VA Joint Program as set out by the Administrative Board at its June 21, meeting. To recapitulate, the meeting will be held from 4:45 to 6:00 p.m. Monday, November 5, 1973, in the Monroe Room at the Hilton. The meeting format will include no formal presentations, and the program will consist entirely of questions from the floor and responses from a panel which will include the VA Chief Medical Director and Selected Members of his staff. Any written material prepared by the Veterans Administration will be distributed with the Council of Deans Business Meeting Agenda in early October. Dr. Mellinkoff has agreed to chair the meeting.

JAK:st

cc Ed Friedlander

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Spring Meeting of the Council of Deans

Attached is the tentative program for the spring COD meeting developed by the Program Committee consisting of Dr. Papper, Dr. Buchanan and Dr. Cazort.

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COUNCIL OF DEANS SPRING MEETING
April 25 to 28, 1974
The Wigwam
Litchfield Park (Phoenix), Arizona

Theme: Tenure and Collective Bargaining: Implications for Institutional Self Renewal

April 25 - Arrival and Reception - Evening

April 26 - Morning Session

8:30 - 8:45 Welcome - Objectives of the Meeting
Emanuel Papper, COD Chairman

Moderator:

8:45 - 9:30 Keynote Speaker

Suggested:

This speech will provide an overview of the subject matter of the meeting. It will highlight its current significance, and provide a philosophical-historical overview of the movement of ideas and social developments stimulating changes in academic institutions. It will touch such matters as the faculty member as employee and as professional; the development of tenure as a guarantee of academic freedom; the perception of tenure as sinecure and income guarantee; the evolving concept of due process as related to institutional activities; the rise of the union movement in the public and professional sector; the desire for greater participation in decision-making; legal constraints on employment practices (the right to organize, prohibitions on discrimination, etc.).

9:30 - 10:00 "The Scientist/Clinician as Academician"

Will cover the empirical basis for faculty appointments: the peaking of scientific productivity, the average age of achievement in science; career patterns and career objectives of the scientist; factors enhancing initiative and productivity; "managing" the professional.

10:00 - 10:30 Discussion: Discussants - One Dean and Audience

10:30 - 11:00 Coffee

Moderator:

11:00 - 11:30 "Academic Tenure - The Findings of the Commission"

The Chairman of the Commission on Academic Tenure in Higher Education will report the findings of the Commission and give his views on the future of the tenure system and its implications for institutional self renewal.

11:30 - 12:00 "The Legal Framework - Constraints and Implications"

This speech will address the issues arising in a legal context. The right to organize, prohibitions on discrimination, problems of enforcement and compliance, flexibility within the system, prerogatives of the faculty and the institution.

12:00 - 12:30 "How I See It"

A junior faculty member-basic scientist will discuss his reactions to the medical school employment practices: his view of tenure, unionization, and affirmative action programs in relation to his own aspirations, career objectives and his prospects in a financially constrained system.

12:30 - 1:30 Discussion: Discussants - One Dean and Audience

1:30 - 7:00 p.m. No Planned Activity

7:00 - 10:00 p.m.

April 27 - Morning Session

8:30 - 8:45 Moderator of Session - Overview

8:45 - 9:;5 "A Labor Leader Looks at Collective Bargaining of Professionals and Scientists"

A noted labor leader will examine collective bargaining as a method of achieving the salary and career

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objectives of professionals and scientists and relate this process to his view of the academic world.

9:15 - 9:45 "A Trustee Looks at Who Has Control"

This speech will address issues arising from de jure and de facto responsibilities of the Board, the Administration, and the Faculty, as well as complications created by tenure, collective bargaining and external regulation in dealing with the legislature and state agencies.

9:45 - 10:30 Discussion: Discussants - One Dean and Audience

10:30 - 11:00 Coffee

Moderator:

11:00 - 11:30 "Faculty Collective Bargaining in a University System"

An experienced administrator will relate some of the experiences of his institution with collective bargaining. The issues which have surfaced and the lessons learned, especially in the areas of preparing for the process, the conduct of negotiations and living with the results will be the focus of the address.

11:30 - 12:00 "An Appropriate Response"

A Wrap-up Session - with an overview of the issues presented and a recommended approach to handling them.

12:00 - 1:00 p.m. Discussion: Discussants - One Dean and Audience

1:00 - 7:00 p.m. No Planned Activity

7:00 - 10:00 Discussion with the AAMC President, John A. D. Cooper, M.D.

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Moonlighting House Officers

At the June Meeting of the Board the following resolution was adopted:

> "The Board considered the matter of moonlighting house officers and the potentially deleterious impact of this practice on the quality of graduate medical education. The staff was requested to examine the nature and extent of this perceived problem and to report back to the Board on potential methods to curtail this practice, including an analysis of the legal and other consequences of proposed methods."

The material on the following pages is an excerpt from the COTH Survey of House Staff Policy. This survey discloses that inhouse moonlighting is permitted in 41% of the hospitals surveyed, including 31% of university-owned hospitals. A policy prohibiting moonlighting outside of the hospital is enforced at only 40% of the hospitals.

The method of enforcement was not disclosed. Discussions with the Association's Counsel ellicited the opinion that there would appear to be no legal obstacle to the inclusion of a provision prohibiting employment outside the scope of the program in the contract of hospital or program with the house officer as a term and condition of participation in the program.

Investigation of the opposition of certain hospital administrators to the establishment and enforcement of such a policy indicates that such opposition is based on the personal belief that "what one does on his own time is his own business," rather than any well established legal principle.

Requiring such a policy as a condition of accreditation of graduate medical education program would fall within the purview of the Liaison Committee on Graduate Medical Education, the Residency Review Committees now operating under its aegis, and possibly the Coordinating Council on Medical Education. The matter could be placed on the agenda of these groups and there appears to be no legal impediment to such a standard, provided that there is ample justification for it on educational grounds.

The fact that 41% of hospitals with accredited programs, including 31% of those in university-owned hospitals and 44% of those with major university affiliation permit moonlighting, tends to diminish the persuasiveness of the argument that its prohibition is essential to an approvable program. In addition, there would appear to be a reservoir of public sentiment which could be called upon by opponents of such a policy to raise a political furor to block its establishment.

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Alternatives available for controlling moonlighting, therefore appear to be 1) prohibition by contract, which appears to be legal, enforceable and not inconsistent with the status of house officer as student, and 2) prohibition as an accreditation standard, which, because of the variety of institutional arrangements among the Association's constituents may present substantial problems. The latter approach would need to be fully supported on educational grounds, could stimulate collective action by house officers, and arguably invades institutional perogatives.

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Intra Hospital

Several questions were asked in the survey about each hospital's policy towards using time after duty hours on second jobs or "moonlighting". One of the questions dealt with the policy of the hospital towards the house staff's moonlighting by working in their own emergency room or some other facility in the hospital where they train. Overall, 41% of the hospitals responded that house officers were permitted to moonlight under these circumstances. The results were also examined by grouping the hospitals by affiliation, ownership, bed size, and stipend level. On the basis of hospital affiliation, the policy on this aspect of moonlighting was bimodal. Less of the university-owned and unaffiliated hospitals permitted it, but more than the average proportion of hospitals with major and limited affiliations approved it. When viewed on the basis of hospital ownership, the data indicate that intra-hospital moonlighting is less likely to occur at VA and state hospitals, but greater than half of the church-related, city, or county hospitals permitted it. On the basis of hospital size, moonlighting correlated with the number of beds. Moonlighting is less likely to be permitted in smaller hospitals than in those with larger bed complements.

Moonlighting was also viewed on the basis of the stipends paid to the house officers. The affinity between size of stipend and permission to moonlight was mixed. At those hospitals paying stipends in the lower two quartiles, moonlighting was more often permitted than among the upper two quartiles. However, 35% of the hospitals paying the highest stipends permitted intra-hospital moonlighting compared to only 29% of the hospitals in the third quartile of stipends.

Table 34

House Officers Permitted To Moonlight In Their Own Hospitals, 1972-73

AFFILIATION

Affiliation	Moonlighting Permitted
University-Owned	31%
Major	44
Limited, Graduate	43
Unaffiliated	33
TOTAL	41%

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Table 35

House Officers Permitted To Moonlight In Their Own Hospitals, 1972-73

OWNERSHIP

Ownership	Moonlighting Permitted
State	26%
County	57
City	60
Church	65
Other, Nonprofit	42
V A	19
TOTAL	41%

Table 36

House Officers Permitted To Moonlight In Their Own Hospitals, 1972-73

BED COMPLEMENT

Bed Size	Moonlighting Permitted
Less than 355	28%
355-479	36
480-659	47
660 and Over	47
TOTAL	41%

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Table 37

House Officers Permitted To Moonlight In Their Own Hospitals, 1972-73

STIPEND LEVEL

Stipend Category*	Moonlighting Permitted
Less than $9,500	59%
$9,500-10,499	41
$10,500-11,499	29
$11,500 and Over	35
TOTAL	41%

*Based on 2nd Post-MD year.

Other Than Intra Hospital

Most of the interest in moonlighting has revolved around the employment of house officers outside the hospitals in which they were training. The responses to the questions in the survey indicate that 25% of the hospitals permitted moonlighting outside their own institutions and an additional 35% had a policy against moonlighting but did not enforce it. Thus, only 40% of the hospitals maintained and enforced a policy against moonlighting by their house officers. In Table 38 the policy towards extra-hospital moonlighting is shown on the basis of hospital affiliation. At one extreme, only one-fourth of the university-owned hospitals enforced a policy against moonlighting. At the other extreme, greater than one-half of the unaffiliated hospitals enforced a policy against moonlighting. Hospitals with major and limited affiliations were close to the overall average of 40% which enforced a policy against moonlighting. Moonlighting policies were analyzed on the basis of hospital ownership in Table 39. Nearly all of the county hospitals either permitted moonlighting or did not enforce a policy against it. Relatively few state or city hospitals enforced a policy against moonlighting. At the opposite extreme, only 12% of the VA hospitals permitted moonlighting. Of the remaining 88% of VA hospitals where moonlighting was prohibited as policy, nearly all enforced the policy.

On the basis of stipend levels of hospitals, the data indicate that hospitals in the lower half of the stipend dollar categories enforce their policy against moonlighting less often than hospitals which pay higher stipends. Yet, only 40% of the hospitals paying the highest stipends enforce a policy against moonlighting, compared to 50% of the hospitals in the

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third quartile who enforce their policy. It is quite possible that one or both of the two cities which pay the highest stipends (Los Angeles and New York City) have an undue influence on these data.

Table 38

House Officers Permitted To Moonlight Outside Their Own Hospitals, 1972-73

AFFILIATION

	Percentage of Hospitals Where Moonlighting			
		Not Permitted		
Affiliation	Is Permitted	As Policy	And Enforced	TOTAL
University-Owned	35%	39%	26%	100%
Major	20	37	43	100
Limited, Graduate	32	28	40	100
Unaffiliated	22	22	56	100
TOTAL	25%	35%	40%	100%

Table 39

House Officers Permitted To Moonlight Outside Their Own Hospitals, 1972-73

OWNERSHIP

	Percentage of Hospitals Where Moonlighting			
		Not Permitted		
Ownership	Is Permitted	As Policy	And Enforced	TOTAL
State	41%	38%	21%	100%
County	41	45	4	100
City	0	78	22	100
Church	46	23	31	100
Other, Nonprofit	19	41	40	100
V A	12	16	72	100
TOTAL	25%	35%	40%	100%

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Table 40

House Officers Permitted To Moonlight Outside Their Own Hospitals, 1972-73

STIPEND LEVEL

	Percentage of Hospitals Where Moonlighting			
		Not Permitted		
Stipend Category*	Is Permitted	As Policy	And Enforced	TOTAL
Less than $9,500	43%	35%	22%	100%
$9,500-10,499	30	32	38	100
$10,500-11,499	16	34	50	100
$11,500 and Over	7	39	40	100
TOTAL	25%	35%	40%	100%

*Based on 2nd Post-MD year.

Collective Bargaining

Some of the activities of house officers in the area of collective bargaining are shown in Table 41. One out of every ten hospitals reported that they had received a request for collective bargaining recognition by the house staff since January 1, 1972. When these requests were analyzed on the basis of several categories of teaching hospitals, a profile could be constructed of those categories in which collective bargaining recognition was sought with greatest frequency. The profile is shown below:

Profile of the Most Frequent Requests for Collective Bargaining, Since 1972

Category	Variable	Percentage
Region	Western	16%
Affiliation	University-Owned	15
Ownership	County	43
Bed Size	355-479	16
House Staff Size	>159	19
Stipend Level	>$11,500	20

Post-M.D. Clinical Training Opportunities

The attached material is provided by way of a progress report on the examination, currently underway, of the availability of clinical training opportunities.

The data indicate that in terms of aggregate numbers of positions, sufficient places should be available through 1976-77 on the assumptions used. This throws no light on the quality of the programs (except by the gross measure of their affiliation), nor on their distribution by specialty.

The next refinement will be to examine the specialty distribution of the places available. It is possible that this step will be completed by the time of the meeting.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Report to Executive Council
Concerning Post-M.D. Clinical Training Opportunities*

A. Background

At its meeting of June 22, 1973, the AAMC Executive Council directed staff "to undertake an examination of the availability of appropriate post-doctoral clinical training opportunities for the increasing numbers of graduates of medical schools over the next several years." It was further indicated that "such an examination should explore the phenomenon of the increasing numbers of graduates unmatched through the NIRMP and the impact of the phaseout of the freestanding internship. This matter should be brought to the attention of other appropriate bodies, such as the Coordinating Council on Medical Education. An assessment of the situation and recommendations for influencing its redress should be presented in a time span which would permit appropriate remedial action if necessary."

B. Findings

1. There should be ample internship and residency positions for the increasing numbers of graduates of U.S. medical schools in the years ahead. As indicated in Figure 1, the projected house staff positions filled by U.S. and Canadian graduates (line #4) is well below both the number of projected available positions in affiliated hospitals (line #3) and the positions available in all hospitals (line #1). This is true not only when the number of available positions is conservatively projected as growing at 2% per year (lines #1a and #3a) but also when zero growth is projected (lines #1b and #3b). If zero growth in affiliated hospital positions were projected beyond 1977-78, there could be a slight shortage of such openings for U.S. and Canadian graduates starting in 1979-80.

2. As regards graduates of foreign medical schools, however, Figure 1 shows that there is already a lack of enough positions in affiliated hospitals for total FMG's and non-foreign graduates (line #3). If the growth in total positions offered is projected at 2% (line #1a), there could be a shortage of spaces for FMG's by 1977-78; whereas if zero growth is projected (line #1b), this shortage for FMG's could begin as early as 1975-76.

3. Expressed in numerical terms for 1975-76, Table 1 projects that 45,693 graduates of U.S. and Canadian medical schools (column 6) will be in post-doctoral training as interns and residents. Assuming a 2% growth rate, the total positions offered would be 71,024 (column 2) and the affiliated positions would be 61,905 (column 4). The former would provide a surplus of 25,331 places for non-foreign graduates while the surplus in affiliated hospitals would be 16,212. Even with a zero growth rate, total positions would be 65,615 (for a surplus of 19,922) and affiliated offerings would be 54,496 (for a surplus of 8,803).

4. If the projected 22,217 house staff from foreign medical schools for 1975-76 are added (column 8), Table 1 indicates that the total potential

*Prepared by Dr. Davis G. Johnson, AAMC Division of Student Studies, and Mr. Armand Checker, AAMC Department of Teaching Hospitals.

interns and residents would be 67,910 (column 10). Comparing this with the 71,024 total positions projected by a 2% growth rate would leave a surplus of 3,114 offerings. Assuming zero growth, however, the resulting 65,615 total positions would mean a shortage of 2,295 openings for FMG's. In terms of affiliated positions, there would be a shortage of 6,005 (67,910 - 61,905) with a 2% growth rate; and a shortage of 11,414 (67,910 - 56,496) with zero growth in such positions. Again, it is expected that most, if not all, of any reduction in house staff members at affiliated hospitals would be from the ranks of the foreign medical graduates.

5. To date, financial considerations do not seem to be a limiting factor in the supply of house staff positions in major teaching hospitals. For example, a 1973 COTH survey revealed a net increase of 906 funded house staff positions in the 161 teaching hospitals reporting a change in their number of positions for July, 1973. In the future, however, there might be a decrease in positions for financial reasons, especially if third-party reimbursement of house officers is curtailed. Conversely, forces suggesting an increase in house staff positions include a) the increased number of U.S. medical school graduates which will give many hospitals more desirable candidates for house officer positions and b) the additional house officers required to staff the hospitals of the newly developing medical schools.

6. Although the number of U.S. graduates "unmatched" via the NIRMP has increased steadily from 218 (2.6%) for 1970-71 to 556 (5.5%) for 1973-74 (see Table 3), this trend does not affect either the total number of house staff positions available or the total number of positions eventually filled. It may indicate that current graduates are tending to "aim higher" than past graduates. Another possibility is that the increasing number of graduates from more schools has raised the level of competition for places at the more prestigious hospitals. (Dr. Cooper's office has requested additional information from Dr. Nunemaker at the NIRMP relative to possible reasons for this increase in "unmatched" students.)

7. As far as AAMC staff were able to determine, the phaseout of the "freestanding internship" may not have too great an impact on the general availability of appropriate post-doctoral clinical training opportunities. This is believed in part because of the relatively small number of hospitals offering such internships but no residencies. According to Table 23 on page 1005 of the 1971-72 Education Issue of JAMA, there were 62 hospitals with "internships only" as of September 1, 1971. These comprised only 4 percent of all U.S. hospitals and only 5 percent of the total beds in U.S. teaching hospitals. Review of the 1972-73 Directory of Approved Internships and Residencies indicates that these 62 hospitals offered approximately 650 internship positions, of which they filled about 100. According to Dr. C. H. William Ruhe's memo of March 18, 1971 on "Implications of Recent Actions to Integrate Internship and Residency Programs," the definition of "free-standing internships" includes "an internship offered in a hospital that has approved residencies, but that offers the internship as a discrete experience with no indication that it is coordinated with residencies in the same hospital or elsewhere." Although it is assumed that most of these internship programs would become integrated with residencies in the same or other hospitals, adequate advance planning must be done prior to the July 1, 1975 dead-

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line for phasing out the "free-standing internship." This may be particularly important to insure that house staff in so-called "pyramid" programs will be able to progress without delay through the successive years of post-M.D. clinical training.

8. Even though the overall supply and demand situation for house staff appears favorable, however, it is possible that problems will arise in selected areas unless appropriate intervention is brought about. Examples of these problem areas include:

a. A possible shortage of first-year positions in internal medicine or in rotating (newly named flexible) programs required as a prerequisite for more advanced clinical training in some specialties. (Table 3 of the attached Datagram, for example, shows a reduction in matched rotating internships from 4,726 in 1968 to 3,304 in 1972. Comparable data for 1973 has been requested from the NIRMP.)

b. A possible shortage of positions in certain specialties. (Table 9, for example, suggests potential future shortages of residencies for U.S. and Canadian graduates in affiliated hospitals in such specialties as Diagnostic Radiology, Dermatology, Ophthalmology and Orthopedic Surgery. In all of these fields, over 90 percent of offered positions in affiliated hospitals were filled for 1971-72 and less than 10 percent were filled by FMG's.)

c. Some of the newly developing medical schools may build their undergraduate programs more rapidly than their internship and residency programs, which might contribute to at least a temporary imbalance between their graduates and available house staff positions offered.

d. The anticipated reductions in NIH/NIMH-supported trainees may result in an increased demand for house staff positions supported by non-federal funds. For example, the recent "AAMC Survey of the Impact of the Proposed FY 1974 Budget on Selected Departmental Disciplines" reported the following anticipated decreases in trainees from 1972-73 to 1973-74: Internal Medicine - 10%; Pediatrics - 13%; and Psychiatry - 48%.

9. Staff analysis also revealed a number of pertinent questions for which data were not fully available. These questions include the following:

a. What type of internships are the "unmatched" students applying for?

b. Are students in "accelerated programs" more apt to seek broad training in their first post-graduate year than students in regular programs?

c. Exactly how many "free-standing" internships of what types are there and in what categories of hospitals?

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C. Recommendations

1. It is recommended that this report (or a modification thereof) be forwarded to the Coordinating Council on Medical Education for their information and guidance.

2. It is recommended that steps be taken to assure continued monitoring of the types of trends and issues identified in this report.

DGJ/sg

Attachments

1. Figure 1 - Graph of Post-M.D. Clinical Training Opportunities, 1967-68 Through 1977-78.
2. Table 1 - Analysis of Post-M.D. Clinical Training Opportunities, 1967-68 Through 1977-78.
3. Explanation of Table 1.
4. Table 2 - Projections of Graduates from U.S. Medical Schools.
5. Table 3 - Trends in Number of U.S. Medical School Graduates Matched via the NIRMP.
6. January, 1973 Datagram on "The National Intern and Resident Matching Program, 1966-72."
7. Table 9 - Number of Residencies by Specialty in Affiliated and Nonaffiliated Hospitals (from p. 998 of 1971-72 Education Number of JAMA).

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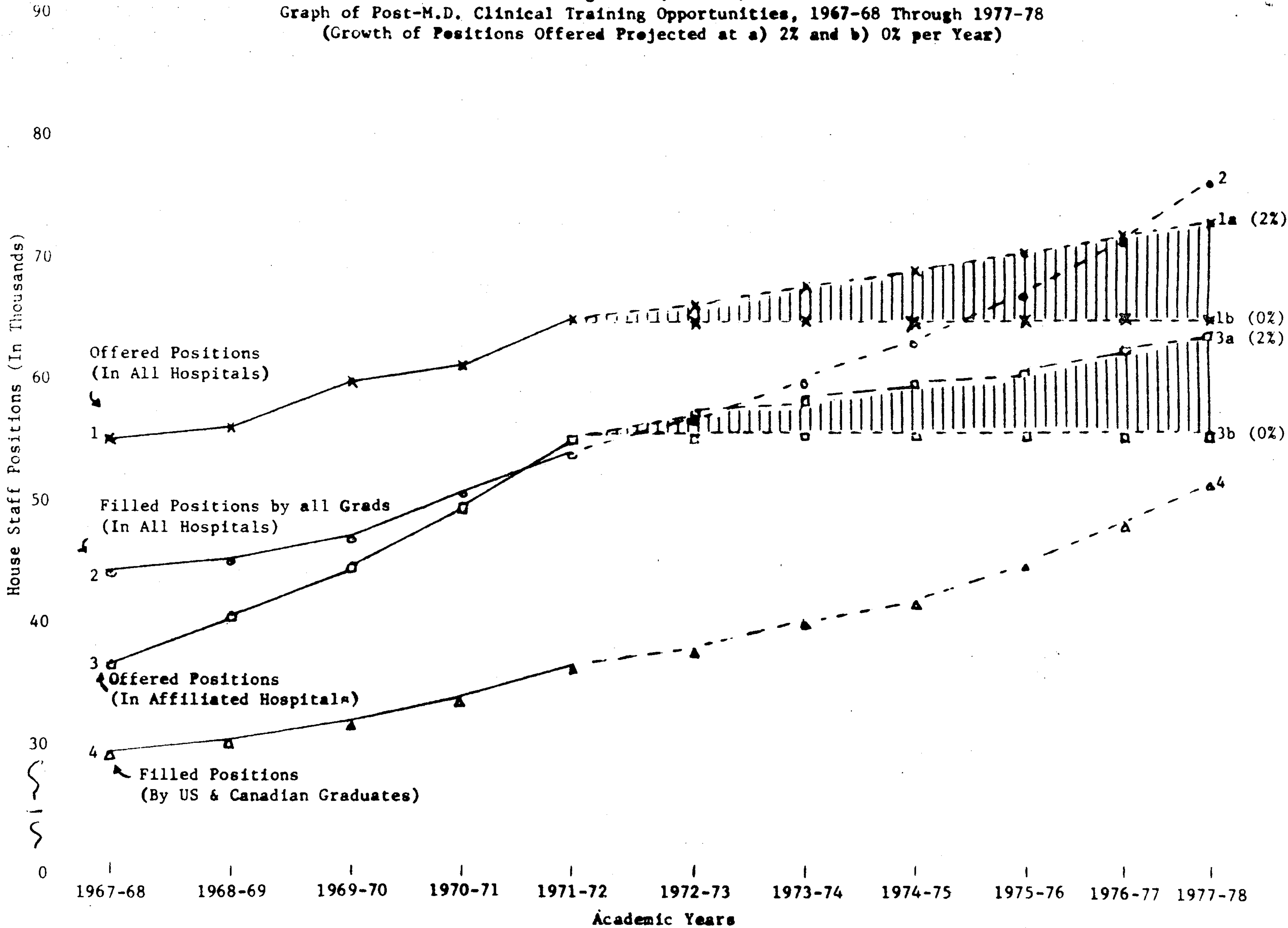

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Table 1 (Revised) - Analysis of Post-M.D. Clinical Training Opportunities, 1967-68 Through 1977-78
(Growth of Positions Offered Projected at 2% per Year)*

Academic Year (1)	Total Positions Offered No. (2)	Total Positions Offered % Growth (3)	Offered in Affiliated Hospitals No. (4)	Offered in Affiliated Hospitals % Growth (5)	Positions Filled (or Potential Candidates for Projections): U.S. & Can. Grads No. (6)	U.S. & Can. Grads % Growth (7)	Foreign Grads No. (8)	Foreign Grads % Growth (9)	Total No. (10)	Total % Growth (11)
A. Actual Figures										
1967-68	55,456	-	37,623	-	30,622	-	13,540	-	44,162	-
1968-69	56,745	2.3	41,448	10.2	31,010	1.3	14,501	7.1	45,511	3.1
1969-70	60,354	6.4	45,700	10.3	32,882	6.0	15,065	3.9	47,947	5.4
1970-71	61,938	2.6	50,649	10.8	34,708	5.6	16,307	8.2	51,015	6.4
1971-72	65,615	5.9	56,496	11.5	37,090	6.9	17,489	7.2	54,579	7.0
B. Projected Figures										
1972-73	66,927	2.0	57,808	2.3	38,668	4.3	18,671	6.8	57,339	5.1
1973-74	68,266	2.0	59,147	2.3	40,510	4.8	19,853	6.3	60,363	5.3
1974-75	69,631	2.0	60,512	2.3	42,924	6.0	21,035	6.0	63,959	6.0
1975-76	71,024	2.0	61,905	2.3	45,693	6.5	22,217	5.6	67,910	6.2#
1976-77	72,444	2.0	63,325	2.3	49,034	7.3	23,399	5.3	72,433	6.7
1977-78	73,893	2.0	64,774	2.3	52,264	6.6	24,581	5.1	76,845	6.1

#See sections B3 and 4 for discussion of projections for 1975-76.

*For projections at 0% growth per year, total house staff positions offered remains at 65,615 and affiliated hospital house staff positions offered remains at 56,496.

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Explanation of Table 1 (Revised) - Analysis of Post-M.D. Clinical Training Opportunities, 1967-68 Through 1977-78

Column	Explanation
1 - Year	Data from hospitals for a given academic year (e.g. 1971-72) was obtained as of September 1 (e.g. September 1, 1971).
2 & 4 - Positions Offered	Actual figures from Table 25 on page 1006 of 1971-72 Education Number of JAMA. Projected figures for offered positions calculated at increasing by 2% per year, with the assumption that all of these new positions would be in hospitals affiliated with medical schools.
3 & 5 - Percent Growth in Offered Positions	Even though actual growth rates for all positions ranged from 2.3% to 6.4% per year, the projected rate was set at 2% in Column 3 to give the most conservative projections from these data. Comparison of the projected 2.3% growth in affiliated positions with the 10.2% to 11.5% actual increase indicates the projections in column 5 are even more conservative.
6 & 7 - Positions filled by U.S. & Canadian Graduates	Actual figures in column 6 from Table 25 noted above. (Figures include both U.S. and Canadian graduates). Projected figures based on actual and projected U.S. grads. of 1972 through 1978, using the formula a + b - c = d as indicated below: a) Non-foreign filled positions of given year (e.g. 37,090 for 1971-72). +b) U.S. medical students entering graduate training that year (e.g. 9,551 graduated in 1972). (For the years for which actual numbers of graduates were unavailable, estimates were based on 95% of entrants four years earlier as indicated in Table 2). -c) U.S. graduates four years earlier who are assumed to have completed house staff training that year (e.g. 7,973 graduated in 1968) and were assumed to have completed post-M.D. training in 1972. =d) Filled positions for following year (e.g. 38,668 for 1972-73). Since the number of Canadian graduates entering and leaving U.S. house staff training is relatively constant, it was not necessary to include them in the formula. Column 7 indicates the percentage of growth from the previous year to the given year.
8 & 9 - Positions filled by Foreign Graduates	Actual figures in Column 8 from Table 25 noted above. Projected figures derived by using "basic" projection on page B.5 of Draft Edition of BHME Report No. 73-94 entitled "The Foreign Medical Graduate and Physician Manpower in the United States." This "basic" projection assumes that the increase from 1970-71 to 1971-72 (i.e. 1,182) will continue into the years ahead. Column 9 indicates % growth from previous to given year.
10 & 11 - Total Positions Filled	Actual figures in Column 10 from Table 25 noted above. Projected figures by totaling columns 6 and 8. Column 11 shows % growth from previous to given year.

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Table 2

Projections of Graduates from U.S. Medical Schools

Year of Graduation (1)	No. of Graduates (2)	No. of Enrollees 4 years earlier (3)	Column 2 as % of column 3 (4)
	A. Actual		
1968	7,973	8,856	(90.2)
1969	8,059	8,760	(92.0)
1970	8,367	8,991	(93.1)
1971	8,974	9,473	(94.7)
1972	9,551	9,863	(96.8)
	B. Estimated		
1973	9,901*	10,422	(95)
1974	10,781*	11,348	(95)
1975	11,743*	12,361	(95)
1976	12,892*	13,570*	(95)
1977	13,131*	13,822*	(95)
1978	13,585*	14,300*	(95)

Column	Sources of Data
(2)	Figures for 1968 through 1972 from Table 21 on p. 982 of Education Issue of JAMA for 1971-72. Figures for 1973 through 1978 estimated from enrollees four years earlier, with ratio held constant at 95%.
(3)	Figures from p. 16 of 1974-75 Medical School Admission Requirements.

* Estimated.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TABLE 3

TRENDS IN NUMBER OF U.S. MEDICAL SCHOOL GRADUATES
MATCHED VIA THE NIRMP*

Status of Application	Year For Which Matched							
	1970-71		1971-72		1972-73		1973-74	
	No.	%	No.	%	No.	%	No.	%
Matched	7,732	92.9	8,107	91.5	8,389	88.4	8,969	88.6
Unmatched	218	2.6	310	3.5	369	3.9	556	5.5
X'ed All Choices #	96	1.2	105	1.2	104	1.1	86	.8
Did Not Return List	26	.3	66	.7	107	1.1	316	3.1
Withdrew	255	3.1	270	3.0	525	5.5	198	2.0
Total	8,327	100.1	8,858	99.9	9,494	100.0	10,125	100.0

*From information reported by NIRMP Staff to the NIRMP Board of Directors for their meeting of May 8, 1973.

#Indicated unwillingness to be matched at any of the hospitals applied to via the NIRMP.

DGJ/aaj 9/11/73

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DATAGRAM

The National Intern and Resident Matching Program, 1966–72

The National Intern Matching Program was created 21 years ago to provide an orderly process for the selection and appointment of interns. The objective of the program is to match the intern applicant and the hospital seeking house staff at the highest level of preference for both. Since 1968 the matching plan has also been available for some residency appointments.

The program procedure is as follows. A medical student registers with the program and makes applications to the hospitals of his choice. Then he sends to the program a list of the hospitals to which he has applied, ranked in order of preference. The hospital in turn ranks the applicants and files this information with the program. Each April the two lists are matched through a computer application.

The results of the National Intern and Resident Matching Program in 1972 reflect changes in medical education during the past few years, such as the larger medical school enrollment, the advent of residency matching, the increase of foreign medical graduates in the matching program, and the advent of the new family practice specialty.

Recent Trends

The number of participants who were matched and who were not matched in the program is shown in Table 1 for three types of educational background: U.S. medical school graduates, foreign medical school graduates, and graduates of U.S. osteopathic schools and Canadian medical schools. The total for both matched and unmatched U.S. graduates has risen steadily since 1966, the former by approximately 1,250 and the latter by approximately 175. This is a direct reflection of the increasing number of U.S. medical school graduates brought about by enlarged enrollment and accelerated programs. The participation of the foreign medical graduates in the program, after a decrease in 1970 and 1971, rose to a high of 584 in 1972. Moreover, a recent change in the regulations for the program which makes it more accessible to graduates of foreign medical schools is expected to result in a significantly higher number for 1973.

U.S. Medical School Graduates

The participation of U.S. medical school school graduates in the matching program in the period 1966-72 is shown in Table 2. While the numbers of medical school graduates, candidates matched, and candidates who were not matched have generally increased since 1966, the percentage of medical school graduates matched was 94 percent in 1966 but only 88 percent in 1972. The percentage of medical school graduates who did not take part in the program was three percent of all graduates in 1966 and eight percent of all graduates in 1972.

Among possible reasons for not using the matching program are the choice by some students to pursue a career pattern which does not require graduate medical education, late selection of the desired hospital, and the decision to negotiate privately. Factors which could have determined this latter decision include spouses wanting to intern together, appointments at Air Force hospitals which now are outside the program, and students who believe they can make a satisfactory choice at nonparticipating hospitals.

Type of Internships Matched

Trends in choosing between rotating and straight internships by medical school graduates who matched through the program are depicted in Table 3. In spite of the larger number of participants in the program each year, the numbers who matched into rotating internships declined in each of the years since 1968. At the same time, straight internships grew more popular and during the last two

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TABLE 1

NUMBER OF PARTICIPANTS IN THE NATIONAL INTERN AND RESIDENT MATCHING PROGRAM, 1966–72

Year	All Participants			Graduates of U.S. Medical Schools			Graduates of Foreign Medical Schools			Graduates of Canadian and Other Schools		
	Total	Matched	Unmatched	Total	Matched	Unmatched	Total	Matched	Unmatched	Total	Matched	Unmatched
1966	7,836	7,588	248	7,321	7,128	193	406	354	52	109	106	3
1967	8,000	7,753	247	7,494	7,290	204	428	386	42	78	77	1
1968	8,306	8,007	299	7,758	7,502	256	449	411	38	99	94	5
1969	8,393	8,114	279	7,810	7,597	213	487	424	63	96	93	3
1970	8,387	8,113	274	7,950	7,732	218	283	244	39	154	137	17
1971	9,004	8,599	405	8,417	8,107	310	361	301	60	226	191	35
1972	9,534	9,044	498	8,758	8,389	369	584	490	94	200	165	35

Source: NIRMP

years were chosen by a majority of those who matched through the program. Choices of straight medicine internhsips accounted for most of the increase, but all five of the specialties in which straight internships were offered had a similar trend. Obstetrics-gynecology, in particular, had a sharp increase from 16 straight internship placements in 1968 to 95 placements in 1972.

Residency Matching

In 1968, the National Intern Matching Program (NIMP) became the National Intern and Resident Matching Program (NIRMP) with the enlarged mission to match any type of first-year appointment to graduate medical training. Depending upon the option of the organizations sponsoring the specialty training, medical school graduates now can use

TABLE 2

PARTICIPATION OF U.S. MEDICAL SCHOOL GRADUATES IN NIRMP

Year	Participants			Nonparticipants	
	Total	Matched	Unmatched	Number	Percentage of Graduates
1966	7,574	7,128	193	253	3
1967	7,743	7,290	204	249	3
1968	7,973	7,502	256	215	3
1969	8,059	7,597	213	249	3
1970	8,367	7,732	218	417	5
1971	8,974	8,107	310	557	6
1972	9,551	8,389	369	793	8

Sources: AAMC and NIRMP.

TABLE 4

DISTRIBUTION OF RESIDENCIES IN THE NIRMP, 1972

Specialty	Number of Positions Offered	Filled
Anesthesiology	55	1
Family Practice	469	296
Internal Medicine	273	49
Neurology	31	13
Neurological Surgery	1	0
Obstetrics-Gynecology	321	98
Ophthalmology	23	11
Orthopedic Surgery	49	8
Otolaryngology	5	0
Pathology	270	20
Pediatrics	118	11
P M & R	21	6
Psychiatry	426	201
Radiology General	151	24
Radiology Diagnostic	5	3
Radiology--Therapeutic	9	1
Surgery	428	127
Urology	27	3
Total	2,682	872

Source: NIRMP.

the NIRMP for placement directly into a residency position or continue to use it for internship placement. Although the full effects of this new option will not be felt for several years, a slight change in the data was visible in 1972. In 1971, 445 residents were matched through the NIRMP; in 1972, as reflected in Table 4, this increased to 872 residents.

Family practice residency programs offered

TABLE 3

NUMBER OF STRAIGHT AND ROTATING INTERNSHIPS MATCHED THROUGH NIRMP

Year	Straight Internships						Rotating
	Medicine	Surgery	Ob-Gyn	Pathology	Pediatrics	Total	
1968	1,711	852	16	130	572	3,281	4,726
1969	2,018	952	25	118	648	3,761	4,353
1970	2,192	563	40	129	741	3,665	3,959
1971	2,476	1,082	70	138	802	4,568	3,585
1972	2,638	1,149	95	141	848	4,871	3,304

Sources: *1968-1969 Directory of Approved Internships and Residencies*, American Medical Association; NIRMP.

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and matched the largest number of residents, accounting for 21 percent of the positions offered and 34 percent of those matched. This specialty also registered the highest percentage (63 percent) of positions filled versus positions offered through the program. Psychiatry and surgery offered almost as many residency positions as family practice, but fewer of them were filled.

ARMAND CHECKER
AAMC Division of Teaching Hospitals
Washington, D.C.

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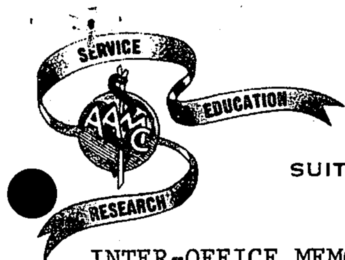
Table 9.—Number of Residencies, by Specialty, in Affiliated and Nonaffiliated Hospitals

Specialty	No. of Approved Programs	Number of Residencies: Total Positions Offered Sept 1, 1971	Total Positions Filled Sept 1, 1971	Positions Vacant Sept 1, 1971	Percentage Filled	Number of Residents on Duty: Graduates US, Canada Sept 1, 1971	Foreign Graduates Sept 1, 1971	Percentage For. Grads. in Filled Positions	Total Residency Positions Offered 1973-1974
Affiliated									
Anesthesiology	162	2,052	1,725	327	84	835	890	52	2,275
Child Psychiatry	96	536	405	131	76	313	92	23	610
Colon and Rectal Surgery	12	18	17	1	94	7	10	59	18
Diagnostic Radiology	60	806	759	47	94	694	65	9	915
Dermatology	84	632	606	26	96	554	52	9	643
Family Practice	78	870	513	357	59	477	36	7	1,563
General Practice	42	228	96	132	42	49	47	49	242
Surgery	378	6,847	5,553	1,294	81	3,770	1,783	32	6,697
Internal Medicine	357	7,774	7,132	642	92	4,846	2,286	32	8,527
Neurological Surgery	93	627	582	45	93	460	122	21	650
Neurology	108	977	840	137	86	598	242	29	1,099
Obstetrics and Gynecology	274	2,758	2,442	316	89	1,563	879	36	2,910
Ophthalmology	146	1,304	1,286	18	99	1,184	102	8	1,359
Orthopedic Surgery	164	2,493	2,416	77	97	2,226	190	8	2,116
Otolaryngology	102	976	922	54	94	782	140	15	1,028
Pathology	428	3,109	2,228	881	72	1,076	1,152	52	3,247
Forensic Pathology	8	21	10	11	48	6	4	40	21
Pediatrics	223	2,894	2,678	216	93	1,709	969	36	3,218
Pediatric Allergy	46	108	96	12	89	80	16	17	119
Pediatric Cardiology	50	160	125	35	78	78	47	38	158
Physical Medicine	62	432	308	124	71	125	183	59	488
Plastic Surgery	91	285	257	28	90	206	51	20	341
Psychiatry	190	4,092	3,386	706	83	2,696	690	20	4,474
Radiology	225	2,419	2,194	225	91	1,761	433	20	2,541
Therapeutic Radiology	47	219	176	43	80	124	52	30	312
Thoracic Surgery	82	283	262	21	93	154	108	41	309
Urology	163	1,037	989	48	95	760	229	23	1,104
Totals	**3,771**	**43,957**	**38,003**	**5,954**	**86**	**27,133**	**10,870**	**29**	**46,984**
Nonaffiliated									
Anesthesiology	18	141	119	22	84	17	102	86	151
Child Psychiatry	40	202	123	79	61	81	42	34	200
Colon and Rectal Surgery	4	10	8	2	80	7	1	13	10
Diagnostic Radiology	4	33	33	..	100	27	6	18	36
Dermatology	3	17	15	2	88	15	..	..	17
Family Practice	25	239	119	120	50	87	32	27	314
General Practice	49	309	150	159	49	26	124	83	334
Surgery	135	1,019	857	162	84	220	637	74	1,104
Internal Medicine	64	825	737	88	89	252	485	66	907
Neurological Surgery	2	13	13	..	100	6	7	54	12
Neurology	3	16	14	2	88	4	10	71	18
Obstetrics and Gynecology	72	419	358	61	85	123	235	66	474
Ophthamology	18	120	117	3	98	103	14	12	122
Orthopedic Surgery	28	185	156	29	84	112	44	28	202
Otolaryngology	6	42	38	4	90	20	18	47	42
Pathology	148	544	306	238	56	57	249	81	572
Forensic Pathology	15	32	10	22	31	6	4	40	32
Pediatrics	27	192	166	26	86	51	115	69	228
Pediatric Allergy	3	2	2	..	100	1	1	50	8
Pediatric Cardiology	1	2	2	..	100	..	2	100	2
Physical Medicine	5	23	3	20	13	1	2	67	25
Plastic Surgery	9	24	22	2	92	14	8	36	30
Psychiatry	74	1,039	699	340	67	291	408	58	1,147
Radiology	38	187	139	48	74	78	61	44	198
Therapeutic Radiology	4	11	9	2	82	7	2	22	28
Thoracic Surgery	4	15	15	..	100	4	11	73	18
Urology	19	75	60	15	80	30	30	50	78
Totals	**818**	**5,736**	**4,290**	**1,446**	**75**	**1,640**	**2,650**	**62**	**6,309**
Grand Totals	**4,589**	**49,693**	**42,293**	**7,400**	**85**	**28,773**	**13,520**	**32**	**53,293**



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 301. 1776 MASSACHUSETTS AVENUE, N.W.. WASHINGTON, D.C. 20036

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INTER-OFFICE MEMORANDUM August 20, 1973

TO: Mr. Joseph Keyes, Director, Division of Institutional Studies

FROM: Dr. Davis G. Johnson, Director, Division of Student Studies

SUBJECT: Study of Post-M.D. Clinical Training Opportunities

This is to report to you and to the Council of Deans Administrative Board relative to activities resulting from its request that AAMC staff "undertake the examination of the availability of appropriate post-doctoral clinical training opportunities for the increasing numbers of graduates of medical schools over the next several years."

Although Mr. Armand Checker of the Department of Teaching Hospitals and I are still in the process of exploring some of the more complex aspects of this question, we can submit to you at this time the following materials:

1) Table 1 - Analysis of Post-M.D. Clinical Training Opportunities

2) Explanation of Analysis

3) Table 2 - Projections of Graduates from U.S. Medical Schools

4) Figure 1 - Graph with growth in positions offered projected at 5% per year

5) Figure 2 - Graph with growth in positions offered projected at 2% per year

6) Table 3 - Trends in Number of U.S. Medical School Graduates Matched via the NIRMP

In general, the first five items suggest that there is no impending shortage of clinical training opportunities for U.S. medical school graduates over the next several years. This is true even when the analysis is limited to opportunities in "affiliated hospitals." On both figures 2 and 3, for example, line no. 4 for "filled positions (non-foreign)" is well below line no. 3 for "positions offered (affiliated)."

It is possible, however, that there may be some shortage of available places for foreign medical graduates in the years ahead. Figure 1 suggests that if offered places grow at the 5% rate, there could be a shortage of positions for foreign graduates in affiliated hospitals but not in all hospitals. Figure 2 suggests that if offered places should only increase at a 2% rate, there could be a slight shortage of total available places for FMG's by 1976-77.

Table 3 summarizes recent trends in the number of U.S. medical school graduates matched via the NIRMP during the past four years. It shows that the proportion of "matched" students has dropped from 92.9% for 1970-71 to 88.6% for 1973-74. A check with Dr. John Nunemaker of the NIRMP reveals that this decrease is explained in part by students aiming too high in their choices.

Continues . . . . .

INTER-OFFICE MEMORANDUM August 20, 1973

After we have completed a more thorough examination of other aspects of the problem, we will be happy to provide another progress report.

DGJ/sg

Attachments (5)

CC: Drs. Knapp and Swanson; Mr. Checker

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Table 1 - Analysis of Post-M.D. Clinical Training Opportunities
1967-68 Through 1977-78

	FILLED POSITIONS			OFFERED POSITIONS			
				Projected at 2% Growth		Projected at 5% Growth	
Year (1)	Non-foreign (2)	Foreign (3)	Total (4)	All (5)	Affiliated (6)	All (7)	Affiliated (8)
			A. Actual Figures				
1967-68	30,622	13,540	44,162	55,456	37,623	55,456	37,623
1968-69	31,010	14,501	45,511	56,745	41,448	56,745	41,448
1969-70	32,882	15,065	47,947	60,354	45,700	60,354	45,700
1970-71	34,708	16,307	51,015	61,938	50,649	61,938	50,649
1971-72	37,090	17,489	54,579	65,615	56,496	65,615	56,496
			B. Projected Figures				
1972-73	38,668	18,671	57,339	66,927	57,808	68,896	59,777
1973-74	40,510	19,853	60,363	68,266	59,147	72,341	63,222
1974-75	42,924	21,035	63,959	69,631	60,512	75,958	66,839
1975-76	45,693	22,217	67,910	71,024	61,905	79,756	70,637
1976-77	49,034	23,399	72,433	72,444	63,325	83,744	74,625
1977-78	52,264	24,581	76,845	73,893	64,774	87,931	78,812

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Explanation of Analysis of Post-M.D. Clinical Training Opportunities, 1967-68 Through 1977-78

1 - Year — Data from hospitals for a given academic year (e.g. 1971-72) was obtained as of September 1 (e.g. September 1, 1971).

2 - Non-foreign filled positions — Actual figures from Table 25 on page 1006 of 1971-72 Education Number of JAMA. (Figures include both U.S. and Canadian graduates). Projected figures based on actual and projected U.S. grads. of 1972 through 1978, using the formula a + b - c = d as indicated below:

a) Non-foreign filled positions of given year (e.g. 37,090 for 1971-72)

+b) U.S. medical students entering graduate training that year (e.g. 9,551 graduated in 1972). (For the years for which actual numbers of graduates were unavailable, estimates were used based on 95% of entrants four years earlier).

-c) U.S. graduates four years earlier who are assumed to have completed house staff training that year (e.g. 7,973 graduated in 1968) and were assumed to have completed post-M.D. training in 1972.

=d) Filled positions for following year (e.g. 38,668 for 1972-73).

Since the number of Canadian graduates entering and leaving U.S. house staff training approximates 100 per year, it was not necessary to include them in the formula.

3 - Foreign filled positions — Actual figures from Table 25 noted above. Projected figures derived by using "basic" projection on page B.5 of Draft Edition of BHME Report No. 73-94 entitled "The Foreign Medical Graduate and Physician Manpower in the United States." This "basic" projection assumes that the increase from 1970-71 to 1971-72 (i.e. 1,182) will continue into the years ahead.

4 - Total filled positions — Actual figures from Table 25 noted above. Projected figures by totaling columns 1 and 2.

5 & 6 - Offered Positions (Projected at 2% growth) — Actual figures from Table 25 noted above. Projected figures for offered positions calculated at increasing by 2% per year, with the assumption that all of these new positions would be in hospitals affiliated with medical schools.

7 & 8 - Offered Positions (Projected at 5% growth) — Same as for columns 5 and 6 except calculated at increasing by 5% per year.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Table 2

Projections of Graduates from U.S. Medical Schools

Year of Graduation (1)	No. of Graduates (2)	No. of Enrollees 4 years earlier (3)	Column 2 as % of column 3 (4)
	A. Actual		
1968	7,973	8,856	(90.2)
1969	8,059	8,760	(92.0)
1970	8,367	8,991	(93.1)
1971	8,974	9,473	(94.7)
1972	9,551	9,863	(96.8)
	B. Estimated		
1973	9,901*	10,422	(95)
1974	10,781*	11,348	(95)
1975	11,743*	12,361	(95)
1976	12,892*	13,570*	(95)
1977	13,131*	13,822*	(95)
1978	13,585*	14,300*	(95)

Column	Sources of Data
(2)	Figures for 1968 through 1972 from Table 21 on p. 982 of Education Issue of JAMA for 1971-72. Figures for 1973 through 1978 estimated from enrollees four years earlier, with ratio held constant at 95%.
(3)	Figures from p. 16 of 1974-75 Medical School Admission Requirements.

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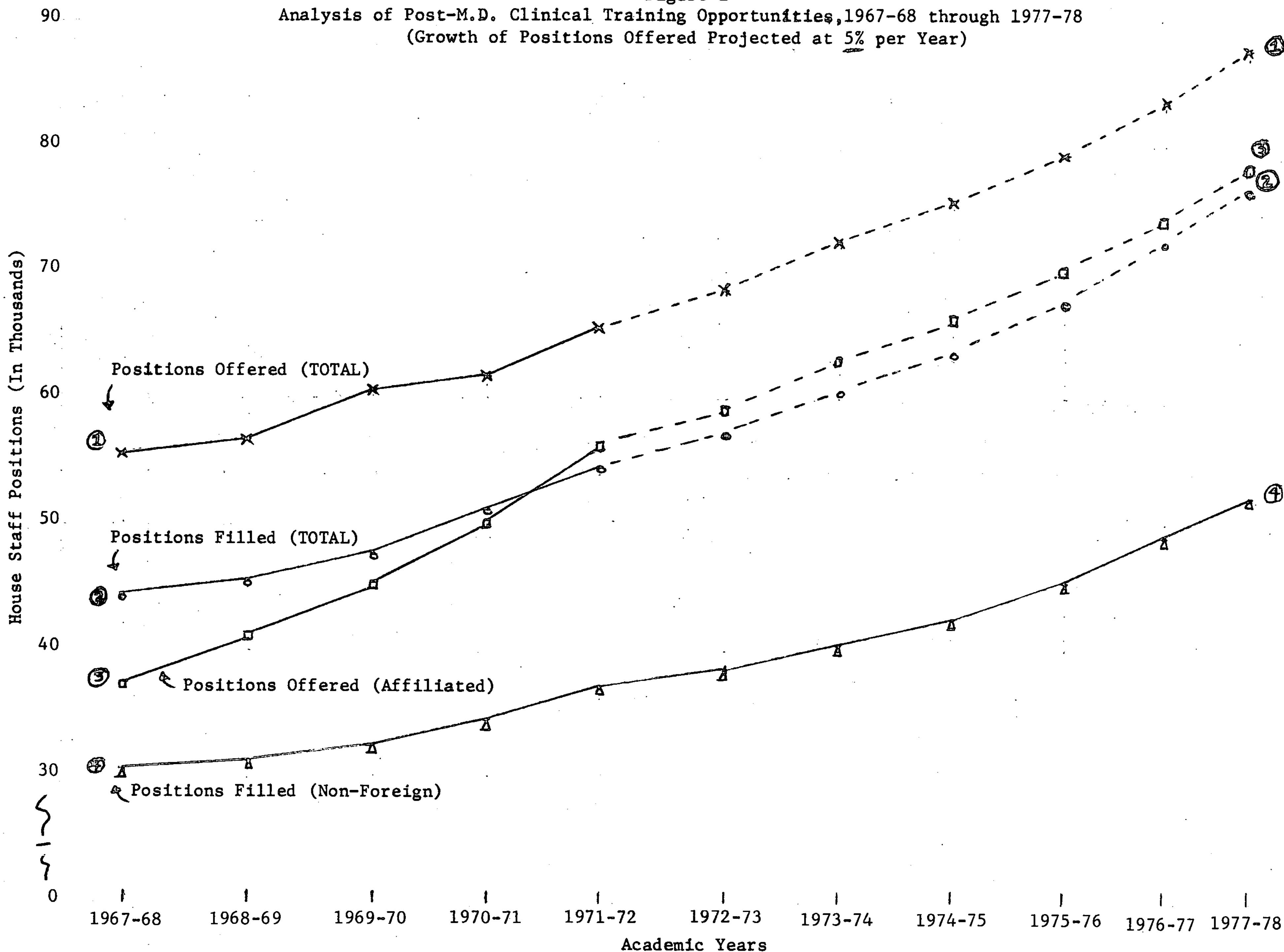

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Association of American Medical Colleges

Figure 2

Analysis of Post-M.D. Clinical Training Opportunities, 1967-68 through 1977-78

(Growth of Positions Offered Projected at 2% per Year)

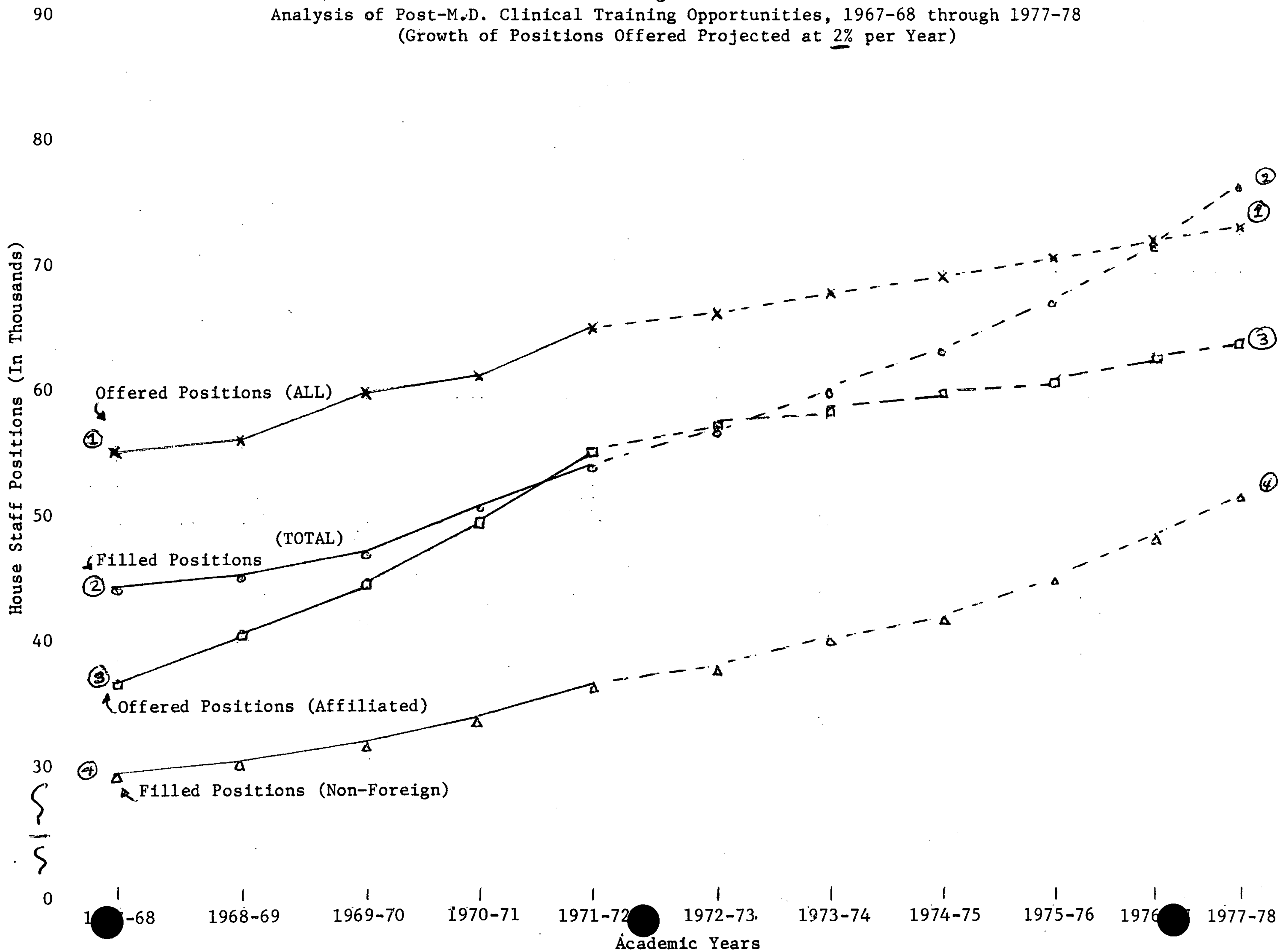

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TABLE 3

TRENDS IN NUMBER OF U.S. MEDICAL SCHOOL GRADUATES MATCHED VIA THE NIRMP*

Status of Application	Year For Which Matched							
	1970-71		1971-72		1972-73		1973-74	
	No.	%	No.	%	No.	%	No.	%
Matched	7,732	92.9	8,107	91.5	8,389	88.4	8,969	88.6
Unmatched	218	2.6	310	3.5	369	3.9	556	5.5
X'ed All Choices	96	1.2	105	1.2	104	1.1	86	.8
Did Not Return List	26	.3	66	.7	107	1.1	316	3.1
Withdrew	255	3.1	270	3.0	525	5.5	198	2.0
Total	8,327	100.1	8,858	99.9	9,494	100.0	10,125	100.0

*From information reported by NIRMP Staff to the NIRMP Board of Directors for their meeting of May 8, 1973.

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Admissions Committee Follow-Up

The attached material is provided by way of follow-up on the action of the Council of Deans at its November 3, 1972 in adopting certain recommendations of the Ad Hoc Committee to Study Medical Student Admissions. This document provides a listing of available annotated bibliographies and requests the Board's guidance with respect to further refinements. Several options are listed on pages three and four of the attached.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 301. 1776 MASSACHUSETTS AVENUE. N.W.. WASHINGTON. D.C. 20036

INTER-OFFICE MEMORANDUM August 20, 1973

TO: Mr. Joseph Keyes, Director, Division of Institutional Studies

FROM: Dr. Davis G. Johnson, Director, Division of Student Studies

SUBJECT: Progress Report Concerning Educational Material for Admissions Committees

This is to provide the Administrative Board of the Council of Deans with a progress report on their recommendation to the Council of Deans Business Meeting of November 3, 1972 that AAMC staff provide appropriate educational material for admissions committee members, including an annotated bibliography on the subject.

At the present time, the following annotated bibliographies are readily available for use by admissions officers:

1) The AAMC Annotated Bibliography on "Admissions and Student Affairs." Last revised in October, 1971, this bibliography includes thirty-one references on admissions plus a number of others on attrition, financial aid and other related topics.

2) Selected Bibliography on the Admissions Process. This ten-item annotated bibliography appeared in the agenda book for the February 4, 1972 joint meeting of the Council of Deans and Council of Academic Societies.

3) The AAMC Annotated Bibliography on "Minorities and the Health Professions." This appeared in the Fall of 1972 and includes 208 references published since 1967. Detailed indices give ready reference to articles pertinent to admissions. For example, of the 208 references, 16 are indexed to admissions in general, 9 to barriers to admission, 16 to selection criteria and 6 to the admission of minority group women.

4) The Annotated Bibliography on "Research Studies of Medical Students and Physicians Utilizing Standard Personality Instruments" by William Schofield, Ph.D., Chairman of the AAMC Committee on Measurement and Personality. Five copies of this 54-page bibliography were distributed to the dean of each medical school in October and November of 1972.

In addition to these annotated bibliographies, appropriate AAMC publications are also used to publicize newly available educational materials for admission committee members. Since the action of the Council of Deans last Fall, an increasing effort has been made to include such items in the following publications, all three of which go to medical school deans and to all members of the Group on Student Affairs:

1) Student Affairs Reporter (STAR) - During the past year, STAR has included annotations of the last two bibliographies listed above plus such items as a) a Professional Audit for Admissions Officers, b) Results of Survey of Non-cognitive Tests Used in Admission to Medical Schools, and c) Medical Student: Doctor in the Making. In addition to these annotated items, STAR has called attention to pertinent Journal articles and Datagrams concerning minority group admissions, legal considerations, foreign medical schools, applicant studies, etc.

2) The Advisor - Articles during the last year of particular pertinence to admissions committee members include the following:
   a) Letters of recommendation.
   b) Foreign medical school as an alternative choice.
   c) Report on the DeFunis vs. Odegard Case whereby the professional schools admissions committees' policies were upheld.
   d) Relation of medical school admission to one's undergraduate major, academic average, MCAT score and state of residence.

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3) The MCAAP Report - The July, 1973 issue included a "Reading Resource List Related to Admissions, Counseling and Assessment Concerns in Medical Education." Listed (on pps. 7 & 8) are one hundred papers or reports which appeared in the Journal of Medical Education during the periods from a) January, 1970 - May, 1973 and b) January, 1967 - December, 1969. This issue also included a report (pps. 3 & 11) of simulated admissions materials used in AAMC workshops on minority admissions.

In future issues of the above publications, particularly STAR, it is also planned to include annotations of such recent JME articles as Oetgen and Pepper's article on "Medical School Admissions Committee Members" and "Increasing the Efficiency of Medical School Admissions" by Mark Rosenberg. The MCAAP Report will describe new educational and career counseling materials developed as part of the ongoing Medical College Admissions Assessment Program.

Possible next steps in this educational material project include the following:

A. Provision to all admissions officers of a summary of available materials similar to the above, including an updating of the admissions section of the AAMC Annotated Bibliography on Admissions and Student Affairs. The updated bibliography might also indicate with an asterisk those eight or ten items which are felt to be most essential and which should therefore be readily available to all admissions committee members for their perusal.

B. Development of a series of common questions concerning admissions which would be keyed to the above bibliography. For example, the question "What is the relation between applicant characteristics and eventual location and type of practice?" would be keyed to studies by Mattson, Colwill, Weiskotten, etc.

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C. Development of a list of guiding principles for admissions committee members which would be keyed to bibliographic items that support or discuss these principles. For example, the principle that "Students with superior MCAT scores don't necessarily perform any better in medical school than those with above average scores" could be keyed to "Doctor or Dropout?" and to other studies on this topic.

Option A above would be relatively simple to accomplish and could probably be produced in time to distribute to admissions officers early this Fall. Options B and C would be more time-consuming to produce but might be worth attempting if the COD Administrative Board and Senior AAMC staff deem it worth the time and effort. Option A could probably be handled almost entirely by AAMC staff whereas Options B and C would require more consultation with and input from the admissions officers. This consultation process in itself would undoubtedly have an educational value.

DGJ/sg

CC: Drs. D'Costa, Erdmann, Swanson and Thompson
Messrs. Angel, Boerner and Prieto
Ms. Dube and Dulcan

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THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

THE SCHOOL OF MEDICINE
OFFICE OF THE DEAN

July 9, 1973

Sherman M. Mellinkoff, M.D.
Dean
The UCLA School of Medicine
Los Angeles, California 90024

Dear Sherm:

This letter constitutes my report as Chairman of the Council of Deans Nominating Committee to you as the Chairman of the Council of Deans. The Committee met at 12:30 p.m. on June 29 by conference telephone call. At that time we had available to us the tallies of the advisory ballots submitted by the Council of Deans.

Our recommended slate includes nominees for two vacancies which were not indicated on the advisory ballot. The first was created by the resignation of Dr. Stone from the officer of the Association, necessitated by his assumption of his new responsibilities as Director of the National Institutes of Health. The second vacancy, which should have been indicated on the advisory ballots, is created by Dr. Papper's assumption of the office of Chairman of the Council of Deans. The bylaws of the Association provide that the Chairman of the COD shall be a voting, ex officio member of the Executive Council. The COD is entitled to eight representatives on the Executive Council, elected by the Assembly in addition to this ex officio membership. Consequently, we have suggested a slate which includes a nomination to fill this vacancy.

By the unanimous vote of the Nominating Committee, the following slate of officers is proposed:

Chairman-elect of the Assembly: Sherman M. Mellinkoff, M.D., Dean, The UCLA School of Medicine

Council of Deans Representatives to the Executive Council:

John A. Gronvall, M.D., Dean, The University of Michigan Medical School (Midwest-Great Plains)

Clifford G. Grulee, Jr., M.D., Dean, Louisiana State University at Shreveport Medical School (South)

Julius R. Krevans, M.D., Dean, The University of California at San Francisco School of Medicine (West)

Sherman M. Mellinkoff, M.D. July 9, 1973

Note: These offices are filled by election of the Assembly. Consequently, the slate proposed for the Assembly's consideration will be developed by the AAMC Nominating Committee, of which I am a member. Thus, these names will be submitted in the form of a recommendation from our Nominating Committee to that Nominating Committee.

The following offices will be filled by vote of the Council of Deans. The slate proposed by your Nominating Committee is as follows:

Chairman-elect of the Council of Deans: Ivan Bennett, Jr., M.D., Dean, New York University School of Medicine

Member at Large, Council of Deans Administrative Board: Andrew Hunt, Jr., M.D., Dean, Michigan State University College of Human Medicine

These nominations, I believe, accurately reflect the wishes of the members of the Council of Deans. I am confident that we have a slate which will contribute substantially to the work of the Association.

Thank you for the opportunity to serve in this capacity.

Yours truly,

Christopher C. Fordham III, M.D.
Dean

CCF/bh

cc: Joseph A. Keyes
Dr. Clayton Rich
Dr. N. L. Gault, Jr.
Dr. Paul A. Marks
Dr. Leon O Jacobson

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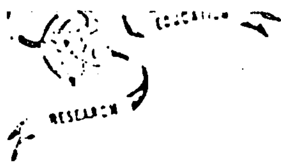

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

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

WASHINGTON: 202: 466-5175

July 27, 1973

Honorable Caspar W. Weinberger
Secretary
Health, Education, and Welfare
Washington, D. C. 20201

Dear Mr. Secretary:

I am writing to you in regard to proposed Social Security Administration regulations as they appear in the July 19, 1973 Federal Register (20 C.F.R. Part 405) (Regulations No. 51), entitled, "Payment for Services of Physicians in Teaching Hospitals and for Physician Costs to Hospitals and Medical Schools and for Volunteer Services," Subparts D and E:

Subpart D - Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Appeals by Provider;

Subpart E - Criteria for Determination of Reasonable Charges; Reimbursement of Hospital Interns, Residents, and Supervising Physicians.

The membership of the Association of American Medical Colleges includes all of the 114 medical schools, more than 400 of the nation's major teaching hospitals and fifty-one academic societies. I believe the proposed regulations will have a substantial impact on all these institutions and organizations. Before commenting specifically on the regulations proposed, the AAMC hopes to analyze this impact in detail.

A responsible determination of how the institutions will be affected requires that the following major studies be conducted in each of our medical schools and teaching hospitals:

(1) a detailed analysis of medical center budgets to determine the full fiscal impact on each institution;

(2) a detailed analysis of the extent to which patients paid the billed physician fees from sources other than public medical

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assistance for each hospital or specified setting within the hospital as required in items (c) (1) (iii) and (c) (3) (ii) under 405.520 of the proposed regulations;

(3) a detailed analysis of the hospital admissions process, as well as institutional procedures with regard to the patient physician relationship, to determine the impact of items (c) (1) (i and ii) under 405.520;

(4) a detailed analysis of the affiliation or contractual arrangements between medical schools and teaching hospitals (It is through such arrangements that professional physician services to patients are provided as well as supervision of a variety of other hospital activities);

(5) a detailed analysis of all costs associated with the provision of professional services in item (4) under 504.451 to determine the equitability of the policy that allowable costs to the medical school may not exceed 105 percent of direct salary, plus applicable fringe benefits, that are incurred solely as a result of services to provider patients;

(6) a detailed analysis of organizational and other implications which will most likely result from the requirements of the proposed regulations.

The AAMC and its membership recognize and appreciate the long and diligent efforts of the SSA and DHEW staff in developing the complex regulations necessary to implement the law as passed by Congress and signed by the President. Because the medical schools and teaching hospitals contribute greatly to the health of the nation and care for a large proportion of Medicare patients and because these intricate regulations may severely affect the financial base on which these institutions operate, we consider it imperative that the somewhat arduous and time-consuming survey outlined above be completed before the AAMC can respond in a way which would be meaningful to the Department.

In view of the serious effect which the proposed regulations may have on the nation's medical schools and teaching hospitals and the need to assess this effect responsibly, the AAMC respectfully requests that the period provided for submitting written comments, suggestions, or objections be extended at least an additional ninety days.

Sincerely,

John A. D. Cooper, M.D.

cc: James B. Cardwell, Commissioner
Social Security Administration

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THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

AUG 29 1973

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

Dear Dr. Cooper:

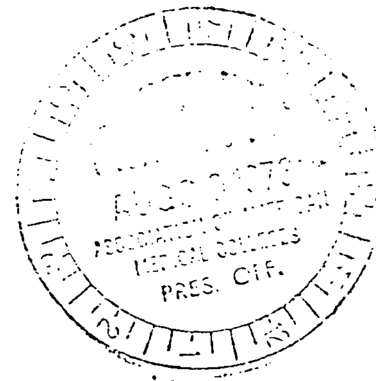
Thank you for your letter concerning proposed Medicare regulations affecting reimbursement to physicians in teaching hospitals.

I'm pleased to report that the time for commenting on these proposed regulations has been extended to October 20, 1973. Notice of the extension is being published in the Federal Register. We look forward to receiving the views of your membership, upon completion of the in-depth analysis outlined in your letter. You may be assured the Association's comments will receive the most intensive consideration prior to promulgation of final regulations.

Sincerely,

Caspar W. Weinberger

Secretary



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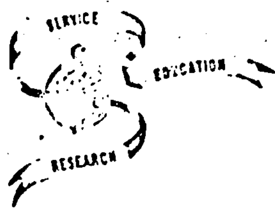

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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

WASHINGTON: 202: 466-5175

August 20, 1973

James B. Cardwell
Commissioner
Social Security Administration
4700 North HEW
Washington, D. C. 20201

Dear Mr. Cardwell:

The purpose of this letter is to provide substantive comments by the Association of American Medical Colleges on the proposed Social Security Administration regulations, which appear in Volume 38 of the Federal Register dated July 19, 1973 (20 C.F.R. Part 405) (Regulations No. 5), entitled, "Payment for Services of Physicians in Teaching Hospitals and for Physician Costs to Hospitals and Medical Schools and for Volunteer Services." Subparts D and E of these regulations are entitled:

Subpart D - Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Appeals by Provider:

Subpart E - Criteria for Determination of Reasonable Charges; Reimbursement of Hospital Interns, Residents, and Supervising Physicians.

These proposed regulations are made pursuant to certain provisions of the Social Security Amendments of 1972 (P.L. 92-603) (the "Amendments") and are stated to be in accordance with congressional intent in enacting such legislation.

These proposed regulations, which provide in Section 405.521(C) that patient care services provided in participating hospitals with approved teaching programs will be reimbursable only where the patient is a "private patient" or only where the criteria of another exception are met, establish certain elements which must be required before a patient will be considered a "private patient". The Association believes that the inclusion of a fiscal test as one of such elements is inconsistent with the intent of Congress in enacting Section 227 of the Amendments and that, consequently, such test should be deleted from the regulations prior to their final adoption.

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Section 405.520(a) of the proposed regulations states: "This health insurance coverage [protection for aged and disabled social security beneficiaries against hospital and medical expenses] is intended to provide a substantial measure of freedom to beneficiaries in selecting the hospital settings and physicians of their choice." Section 405.520(b) of these regulations states: "The basis for reimbursement for such physicians' services depends on the circumstances under which the services are rendered and the nature of the financial obligation to pay for such services" (emphasis supplied). This latter requirement is implemented as a "fiscal test" determining legal obligation to pay which must be met for a teaching physician to bill fees for professional services rendered. The "fiscal test" contradicts the ". . .substantial measure of freedom to beneficiaries. . ." intended in the earlier stated objective of the health insurance program.

Section 227(a) of the Amendments amended Section 1861(b) of the Social Security Act (the "Act"), by striking out the second sentence thereof and inserting a provision whereby reimbursement under the Medicare program for services of physicians performed in a hospital where such hospital has an approved teaching program (as defined) will not be made, unless one of two exceptions are applicable. These two exceptions are the subject of subparagraph (7), which provides:

> "(A) such inpatient is a private patient (as defined in regulations), or, (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients".

The principal concern of the Association in this regard is with the interpretation in the proposed regulations concerning the concept of the term "private patient" as utilized in subportion (A) of paragraph (7), above.

This subparagraph (7), in the overall context of Section 227 of the Amendments and Section 1861(b) of the Act, clearly states two exceptions to the general rule as expressed at the outset of subparagraph (7). The first exception, that of (7)(A), simply requires that the inpatient be a "private patient (as defined in the regulations)." The second exception, that of (7)(B), is more extensive in its requirements, which essentially are threefold: the hospital must establish that [1] during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians, [2] reasonable efforts have been made [by the hospital] to collect in full from all patients, and [3] payment of reasonable charges has been regularly collected [by the hospital] in full or in substantial part from at least 50 percent of all inpatients.

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It is also clear from the face of the statute that the criteria enumerated in item (B) are not to be employed in the context of item (A). This is because, first, item (B) states criteria the teaching hospital must meet for the exception to be available, while the focus of item (A) is on the relationship between the physician and the patient-beneficiary. The availability of the exception in item (A) cannot be made contingent on the criteria of item (B), since the concepts embodied in the two exceptions differ. Of greater importance, however, is the fact that the intent of Congress was not to engraft onto item (A) the elements of item (B); had Congress intended for any of the elements of item (B) to apply with respect to item (A), Congress would have so provided. Since Congress clearly stipulated these elements in item (B) and not in item (A), such elements may not be utilized in the regulations to define the term "private patient". To do so would not only destroy what Congress intended as two alternative and mutually exclusive provisions, but would also violate the well-settled rule that an administrative determination as to the meaning of a particular statute may not go beyond the boundaries of the agency's delegated authority, must be consistent with such statute, and may not seek to alter the meaning of or enlarge the scope of such statute.

The proposed regulations would, in this regard, be contrary to the intent of Congress in enacting Section 227 of the Amendments. Section 405.521(c)(1) of the proposed regulations in the first sentence thereof, states the exception of item (7)(A) of Section 227 of the Amendment, namely, that "In the case of physicians' services rendered during a hospital cost accounting period that began on or after July 1, 1973, where the hospital has or is participating in an approved graduate medical education program, payment on the basis of reasonable charges is applicable to the patient care services rendered to a beneficiary if the beneficiary is a private patient". This proposed regulation then states certain requirements which, if all are met, would give rise to a situation where a "private patient relationship" between a patient and his personal physician (as defined) would be "deemed" to exist. The requirement of chief concern to the Association is that of Section 405.521(c)(1)(iii) (and also Section 405.521(c)(3)(ii)) of the proposed regulations, which injects a "fiscal test" into the definition of "private patient relationship". This section reads as follows:

> "The patient is billed charges for physicians' services in the setting, and reasonable efforts have been made to collect such charges, including applicable deductible and coinsurance amounts. The obligation to pay the billed charges is demonstrated by the fact that during the preceding hospital accounting period at least 50 percent of the physician's patients in the same setting (see paragraph (c)(5) of this section) paid all or a substantial part of his fees from sources other than public assistance programs. (A health insurance patient will be deemed to have paid fees from such private sources only if he paid his supplementary medical insurance deductible and coinsurance relative to those services in full or substantial part

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from private sources and no greater effort was made to collect supplementary medical insurance deductible and coinsurance amounts than the amounts due from other patients.) It will be presumed that the requirements in this subparagraph are met with respect to patients who are admitted from a physician's private practice, which is conducted off hospital and medical school premises, where the physician is not compensated by a hospital, medical school, or other entity and he bills his patients and retains the collections".

Certainly the most striking aspect of proposed regulation Section 405.521 (c)(1)(iii) is its similarity to item (B) of Section 227. The requirements of this section of the proposed regulations would include billing, reasonable efforts at collection, and the existence of an obligation to pay with the existence of such obligation "demonstrated" by a 50 percent test (of collections from non-public sources). These elements of the proposed fiscal test, to be used in ascertaining the actuality of a private patient relationship, are basically the same as those of item (B) of Section 227 of the Act. The Association submits that it is contrary to congressional intent to use the requirements of item (B) of Section 227 in defining terminology in item (A) and that, in so doing, the Department of Health, Education, and Welfare is exceeding its authority by seeking to enlarge and at the same time confuse the meaning and scope of Section 227.

Should this matter be considered by the courts, the questions as to whether the Department of Health, Education, and Welfare has exceeded its delegated authority in this regard may well be resolved solely on the basis of construction of Section 227, taking the statute on its face. However, a court may deem it necessary to consider the legislative history of Section 227, in which case the relevant observations in House Report No. 92-231 and Senate Report No. 92-1230 (the only components of the legislative history of Section 227 containing any material of pertinence) would be scrutinized. After reviewing this legislative history, the Association believes and so submits that Congress did not intend for a "fiscal test" to be among the criteria for determining whether a beneficiary is a "private patient", within the meaning of subparagraph (7)(A) of Section 227 of the Act.

House Report No. 92-231 clearly reflects the fact that Congress intended items (A) and (B) of said subparagraph (7) to be separate exceptions. This report (at p. 96) discusses the exception of item (A) (concerning "private patient") as follows:

> Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to

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him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

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

Several points with respect to the foregoing passage are noteworthy. First, the House report makes clear that the criteria contained therein for determining who is a "private patient' are not exclusive and that Congress recognized that a private patient relationship with a physician may exist absent the existence of one or more of the factors enumerated in the report. Second, the House report, in listing certain characteristics of the private patient relationship, states, among other factors, that the patient is "legally obligated to pay the charges billed" and that the physician "routinely and regularly" seeks collection of such charges. However, nothing in the House report speaks of actual payment or actual collection and no basis for a 50 percent test may be found therein. In fact, as discussed above, Congress has expressly confined the use of any such test to the exception of item (7)(B) of Section 227. Moreover, this legislative history indicates that what Congress was speaking of in this context was not any form of "fiscal test" but was a recognition of the fact that the private patient relationship between the patient and the physician commences when a contractual relationship between the two parties is initiated, that is, when the physician is legally obligated to render services and the patient is legally obligated to pay for or to cause the payment for such services, as more fully discussed below.

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Senate Report No. 92-1230, which likewise expressly reflects the fact that Congress intended items (A) and (B) of subparagraph (7) of Section 227 to be separate exceptions, discusses (at p. 197) the exception of item (A) as follows:

> "Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide 'private patients.' This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physicians. To facilitate efficient administration, a presumption may be made that all of the patients in an institution, or portion of an institution, are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements of care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.
>
> It is recognized, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services.
>
> In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow that pattern of the private patient in such centers. Also, the outpatient department of a hospital may organize the provision of and billing for physicians' services in that department differently from the inpatient setting. In such cases, the decision regarding whether cost

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or charge reimbursement is appropriate, should be made separately for inpatients and outpatients. However, if the services are contracted for on a group basis, and medicare and medicaid directly or indirectly pay for such services, the normal basis for reimbursement for the two programs would be one of cost if the services are provided by a directly or indirectly related organization.

The foregoing discussion in the Senate Report largely tracks the language of the House Report, and therefore, comments on the House report are pertinent to this discussion as well. Of significance, however, is the fact that the Senate committee added a sentence in the first paragraph of the foregoing passage, in which a presumption is raised that all of the patients in a given setting are private patients where the institution offers "satisfactory evidence" that, *inter alia*, the "great majority" of patients pay for the physicians' services. However, this guideline, expressly interposed to "facilitate efficient administration", is only a presumption and is neither a conclusive presumption nor a rule to be wholly determinative of the question. This presumption--which is absent in the House report--may not be converted by the Department of Health, Education, and Welfare by means of regulations into an absolute requirement but may--at the most--be reflected in the regulations as a mere presumption.

By developing this presumption and by making it a part of the pertinent legislative history, Congress has, the Association submits, merely taken notice of the fact that in most instances where a private patient relationship exists the physician is compensated by the patient or by a third party. Thus, the Congress has invoked a presumption of a private relationship where the factor if present--to "facilitate efficient administration". However, Congress clearly avoided the taking of the position that a private patient relationship cannot exist absent collections by the physician of a fee-for-services. (Had Congress intended to take that position, the above referenced presumption would have no meaning and, in fact, would not have even been stated.) Thus, the intent of Congress underlying Section 227 does not warrant the imposition by the Department of Health, Education, and Welfare of a fiscal test in proposed regulation Section 420.521(c).

The Association submits that a private patient relationship may exist between a patient and a physician where collection of a fee by the physician from the patient does not take place. To contend otherwise would be to exclude several recognized private patient relationships. For example, in paragraph (c)(2) under 405.521, the "private patient" relationship between a edicare beneficiary and a consulting physician, pathologist or radiologist is effectively prevented unless the same status applies as to the personal physician or unless such consulting physician meets the requirements of paragraph (c)(1)(iii) of this section. These are unlawful restrictions on the options of the medicare benficiary that are specifically prohibited by Section 1802 of the Social Security Act. Furthermore, in the proposed regulations, the calculation to achieve the fifty percent level specifically excluses any payments from public medical assistance programs to be included (except medicare where coinsurance and deductibles were substantially paid).

This formula therefore makes the assumption that all medicaid patients are nonprivate. There is no reference to the public/private sector dichotomy in the legislative history. It therefore appears arbitrary to exlude these payments where in fact they were, are or should be made.

The Association submits that a private patient is one who mutually with a physician assumes a professional relationship, where the physician simply assumes responsibility for professional care. As part of this relationship (in law, a contractual relationship), the patient may become legally obligated to pay for such care. However, the presence or absence of collection of a fee by the physician is irrelevant to the establishment of the requisite relationship; failure of collection does not destroy or preclude the private patient relationship.

Finally, in a number of institutions, there are agreements with state or local governments which specifically prohibited or presently prohibit fees being billed for specific groups of patients. It is discriminatory and arbitrary to set in motion a requirement which cannot be met simply because a given institution or group of physicians provide service to groups of patients under a state or county agreement. In other words, physicians and institutions in the future will be penalized not on the basis of the physician-patient relationship or the quality of care provided, but because of the economic status of the population they serve.

The Association is aware that this matter of the "legal obligation to pay" was engaged during the hearings before the Senate Finance Committee in July, 1969 and was addressed in chapter 6 of a "Report of the Staff to the Senate Committee on Finance," dated February 9, 1970. However, in each case there was no specific guidance of the nature which appears in Section 405.521 (c)(1)(iii) and (c)(3)(ii) of the proposed regulations.

With regard to the proposed regulation (Section 405.521(c)(1)(iii) and (c)(3)(ii)) as it stands, there are a number of procedural difficulties as well as other serious implications which could result from implementation of the regulations as proposed.

Difficulties in Administering Proposed Regulations

The requirement calls for a full review of the sources of payment for physician services in order to determine if a physician, setting or institution has achieved the necessary 50 percent level of patients who paid the billed fees from sources other than public assistance programs.

A. Many institutions are not in a position to provide data, and many physicians will be rightfully unwilling to do so. (The Hospital Manual Revision HIM-10 provides for alternate documentation under A 254.B 1, 2 and 3, but for one year only, and furthermore, most hospital accounts receivable systems will be unable to provide the data as required. Under such cirsumstance, it will be necessary to suggest that an acceptable sampling procedure be developed.)

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B. It will be very difficult to connect coinsurance and deductible payments to the medicare payments in order to determine which medicare patients or dollars may be included in the calculation to achieve the fifty percent level.

C. The procedure calls for the data on a patient basis, when it would appear administratively desirable to accomplish the percentage calculation on a percent of gross charges, or collections when this method is appropriate.

Other Implications

A. There is an incentive for physicians to admit their patients to other institutions without teaching programs to avoid the regulations. This action would be detrimental to teaching hospital occupancy, detrimental to the educational programs, and detrimental to the relationship of these physicians with their respective teaching hospitals and medical schools.

B. The fiscal test as well as the "setting" concept serve as an incentive to maintain or foster dual systems of care - one for private patients and one for nonprivate patients. Since the advent of medicare, most teaching hospitals have made a definite effort to fully integrate patients without regard to ability to pay. These proposed regulations will prevent further progress in this area and may be an incentive for a social step backward. One would hope that a public policy could be formulated which would serve as an incentive to treat all patients on an equal basis.

C. The fiscal tests will be particularly discriminatory in "public" teaching hospitals which have been struggling to break their image as "charity organizations." This is specifically the case since it is extremely difficult for an institution to make the change from a cost-based reimbursement to a fee-for-service charge because no coinsurance and deductibles are collected on the cost basis. Therefore, medicare patients cannot be included in the effort to achieve the required 50 percent level.

All of the above stated implications as well as the procedural difficulties will serve to discourage many of our most competent physicians from practicing in an academic setting, and make recruitment of teaching physicians a most onerous and difficult task.

There are a number of other points and sections in the proposed regulations which also are of concern to the Association. They are as follows in the order in which they appear in the proposed regulations.

(1) Section 405.451(b)(4): For reasonable costs incurred by a teaching hospital in reimbursing a medical school for the costs to the medical school in rendering services in a hospital, it is stated that, "The allowable costs to the medical school may not exceed 105 percent of direct salary, plus applicable fringe benefits, that are incurred solely as a result of services to provider patients." It is stated on page 198 of the Senate Finance Committee Report that, ". . .this section would permit a hospital to include among its reasonable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services." Surely, what amounts to a five percent overhead rate for services provided by the medical school would not cover the indirect costs for hospitals if they provided the same services.

(2) Section 405.451(b)(5): In defining a volunteer physician the following quote is very significant. "However, where a physician either on the hospital staff or on the medical school staff receives any compensation from either the hospital or the medical school, that compensation will be assumed to represent compensation for the physician's full range of services rendered in the hospital including patient care to nonprivate patients." The effect of this statement is to exclude from consideration as volunteers the large number of physicians who are paid a nominal salary to teach a course in the medical school, supervise the teaching hospital's utilization review program or take responsibility for any one of a number of activities which do not include professional service to nonprivate patients. To make such a policy is inconsistent with the statement in the proposed regulations that, "Such payments represent compensation for contributed medical staff time which, if not contributed would have to be obtained through employed staff on a reasonable basis." It is recommended that this sentence be reworded as follows: "Where a physician either on the hospital staff or on the medical school staff receives any compensation from either the hospital or medical school for patient care services to non-private patients (and/or the supervision of interns and residents in the care of such patients) the physician will not be eligible for inclusion in the report of voluntary services for reimbursement purposes."

(3) Section 405.521(c)(1)(iii): The following statement appears in this section: It will be presumed that the requirements in this subparagraph are met with respect to patients who are admitted from a physician's private practice which is conducted off hospital and medical school premises, where the physician is not compensated by a hospital, medical

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school or other entity and he bills his patients and retains collections." There are a large group of physicians who would meet the full intent and requirements of this statement except that they lease office space from a hospital or medical school. The policy as stated would tend to discourage such leasing arrangements which are definitely in the best interest of patient care and patient convenience.

(4) Section 405.521(c)(4): It is stated that, "The hospital may make this election to receive cost reimbursement only where: (A) the election would reduce the total of benefit payment and administrative costs for which the program would otherwise be liable had the cost option not been elected. . ." The specific intent of this statement would be clearer if the following words were inserted subsequent to the word "liable": "had the fee for service option been elected."

(5) Section 405.521(e): It is stated that, "Where there is a question as to whether reimbursement for the services of physicians in a teaching setting should be made on the basis of costs or charges, reimbursement will be made on the basis of costs." It would appear important to know what would constitute questionable circumstances. Furthermore, the language puts the burden on the physicians or institution to demonstrate eligibility for fee for service reimbursement. In other words, a physician or institution falling under the purview of these proposed regulations is presumed to be on a cost reimbursement basis unless it can demonstrate otherwise.

All of the aforementioned points apply to the Hospital Manual Revision (HIM-10) No. 89 dated July, 1973 and signed by Thomas M. Tierney, Director, Bureau of Health Insurance. However, since this document serves as the implementing instructions for the intermediaries and carriers, the Association's comments are extended to include this document:

(1) In transmittal of the document, it is stated that "Where the necessary coverage determination has not been made by the beginning of the teaching hospital's accounting period, the carrier will suspend reasonable charge reimbursement for physician services in the hospital until it is assured that payment is being made only for covered services in appropriate amounts." This is a very strong statement which in effect directs that payments be suspended immediately unless the data is presently available to demonstrate otherwise. That directive is unreasonable since physicians and institutions had no way of knowing what data would be required of them.

(2) Related to the above and set forth in A. 254.B, 1, 2, and 3

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are alternate documentation requirements which may be accepted in lieu of professional fee data. In view of the strong statement in the transmittal letter from Mr. Tierney, it is respectfully requested that the word "may" in the fifth line under A 254.B be changed to "will."

(3) The footnote #1 under A 253.C defines the functioning basis of a group practice in a manner which is inconsistent with the current functioning of many groups. Thus, if taken literally, a group will be considered a physician for fee-for-service billing only if the group functions solely to provide evening and holiday coverage. All other inpatient care is to be provided by the single admitting physician. Many groups, in particular, small subspecialty groups, such as cardiologists and endocrincologists, both in and out of teaching environments, may assign a member to cover all of the inpatients for their group for certain calendar periods. Upon discharge, the patients are returned to a specific group member for out-patient follow-up. The patients are informed of this arrangement in advance. Under the proposed definition of a group in the Hospital Manual Revision, such rotating inpatient coverage arrangements by the group would appear to be disallowed.

(4) Under A 253. "DEFINITION OF TEACHING SETTINGS" it is stated that the intermediary will evaluate and differentiate among private, non-private and mixed settings. The intent of this paragraph is not entirely clear. It appears that the intermediary can, for one reason or another, reject the settings, identified by the institution and its physicians. It should be made clear that the prerogative of identifying "settings" is definitely an institutional question, and as long as decisions of this nature are made with the guidelines of the regulations, the "settings" should be accepted by the intermediaries. Any alternate would be an interference with the provision of professional services and institutional internal management.

I appreciate very much this opportunity to comment on these proposed regulations on behalf of the members of the Association of American Medical Colleges. If there is any way we can provide clarification of any of the above comments, I would be happy to meet with you or members of your staff.

Sincerely,

John A. D. Cooper, M.D.

cc: Honorable Caspar W. Weinberger

Charles C. Edwards, M.D.

American Hospital Association

TELEPHONE 312 645-9400 / CABLE. ADDRESS: AMHOSP

August 20, 1973

To call writer direct
phone (312) 645-9561

Commissioner of Social Security
Department of Health, Education
and Welfare
Fourth and Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Commissioner

On August 3, 1973, we requested of Secretary Weinberger an extension of ninety (90) days to the period provided for submission of comments on proposed regulations relating to payment of teaching physicians. The extension was requested because of the great significance of this section of the law, and because we have serious concerns about the impact it will have on patients, on educational activity, on relationships between medical staffs and institutional providers of care. Although we have had no response, as yet, to our request, we wish to file with you the attached comments on the proposed regulations as a preliminary document, and request of you that publication of the final regulations be delayed.

As we indicated in our earlier letter, we have met with other interested organizations to review the proposed regulations, and we strongly commend to you the analysis made by the Association of American Medical Colleges. We are fully aware of the continuing effort of that association in attempting to help shape equitable, workable regulations. Their comments, together with our own, should clearly demonstrate the need for further review of the proposed regulations.

We believe it is extremely important to supply emphasis to some of the major points raised in the attached analysis:

1. There is a very real threat that the quality of patient care will be adversely affected by the use of a fiscal test that is related to a "setting concept." Such a consolidation of setting and fiscal test might well serve as an incentive to the establishment or maintenance of dual systems of care.

2. With the Association of American Medical Colleges we challenge the nature of the fiscal test that was designed in the process of drafting of regulations. We have serious reservations concerning those requirements (detailed in the attachment) because they seem to confuse the meaning and scope of Section 227 of the amendments.

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3. We believe it to be impracticable if not impossible for hospitals to obtain payment information, from their own records as well as from closed files of private physicians, in order to determine whether the criterion of a 50 per cent level of collection from sources other than public assistance programs was achieved.

4. It seems extremely unreasonable for the administrators of the program to instruct carriers to terminate all payments on the basis of charges (which were provided for in the original legislation) pending determination of the appropriate method of payment.

5. The confusion and impositions of the proposed regulations might well result in teaching physicians with extensive private practices segregating patients according to the financial arrangements instead of by health care need. In addition to having an undesirable effect on quality of care, such a situation would violate established civil rights provisions and would further interfere with desirable teaching arrangements.

We respectfully request that an opportunity be afforded us to discuss the matters covered in the attached paper, and that publication of the final regulations be delayed until needed revisions are accomplished.

Sincerely

John Alexander McMahon
President

sg
attach.
cc: The Honorable Casper W. Weinberger

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COMMENTS SUBMITTED BY THE AMERICAN HOSPITAL ASSOCIATION
TO THE COMMISSIONER OF SOCIAL SECURITY IN RESPONSE TO
PUBLISHED PROPOSED REGULATIONS TO IMPLEMENT SECTION 227
OF THE SOCIAL SECURITY AMENDMENTS -- AUGUST 20, 1973

The purpose of these comments is to provide substantive response by the American Hospital Association to the proposed Social Security Administration regulations, which appear in Volume 38 of the Federal Register dated July 19, 1973 (20 C.F.R. Part 405) (Regulations No. 5), entitled, "Payment for Services of Physicians in Teaching Hospitals and for Physician Costs to Hospitals and Medical Schools and for Volunteer Services."

These proposed regulations, which provide in Section 405.521(c) that patient care services provided in participating hospitals with approved teaching programs will be reimbursable only where the patient is a "private patient" or only where the criteria of another exception are met, establish certain elements which must be required before a patient will be considered a "private patient". The Association concurs with the opinion stated by the Association of American Medical Colleges in another document that the inclusion of a fiscal test as one of such elements is inconsistent with the intent of Congress in enacting Section 227 of the Amendments and that, consequently, such test should be deleted from the regulations prior to their final adoption.

Section 405.520(a) of the proposed regulations states: "This health insurance coverage is intended to provide a substantial measure of freedom to beneficiaries in selecting the hospital settings and physicians of their choice." Section 405.520(b) of these regulations states: "The basis for reimbursement for such physicians' services depends on the circumstances under which the services are rendered and the nature of the financial obligation to pay for such services" (emphasis supplied). This latter requirement is implemented as a fiscal test, determining legal obligation to pay, which must be met in order for a teaching physician to bill fees for professional services rendered. The "fiscal test" contradicts the ". . .substantial measure of freedom to beneficiaries. . ." intended in the earlier stated objective of the health insurance program.

Section 227(a) of the Amendments amended Section 1861(b) of the Social Security Act (the "Act"), by striking out the second sentence thereof and inserting a provision whereby reimbursement under the Medicare program for services of physicians performed in a hospital where such hospital has an approved teaching program (as defined) will not be made, unless one of two exceptions are applicable. These two exceptions are the subject of subparagraph (7), which provides:

> "(A) such inpatient is a private patient (as defined in regulations), or, (B) the hospital establishes that during the two-year period ending December 31, 1967, and each

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year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients".

The principal concern of the Association in this regard is with the interpretation in the proposed regulations concerning the concept of the term "private patient" as utilized in subportion (A) of paragraph (7), above.

This subparagraph (7), in the overall context of Section 227 of the Amendments and Section 1861(b) of the Act, clearly states two exceptions to the general rule as expressed at the outset of subparagraph (7). The first exception, that of (7)(A), simply requires that the inpatient be a "private patient (as defined in the regulations)". The second exception, that of (7)(B), is more extensive in its requirements, which essentially are threefold: the hospital must establish that [1] during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians, [2] reasonable efforts have been made [by the hospital] to collect in full from all patients, and [3] payment of reasonable charges has been regularly collected [by the hospital] in full or in substantial part from at least 50 percent of all inpatients.

It is also clear from the face of the statute that the criteria enumerated in item (B) are not to be employed in the context of item (A). This is because, first, item (B) states criteria the teaching hospital must meet for the exception to be available, which the focus of item (A) is on the relationship between the physician and the patient-beneficiary. The availability of the exception in item (A) cannot be made contingent on the criteria of item (B), since the concepts embodied in the two exceptions differ. Of greater importance, however, is the fact that the intent of Congress was not to engraft onto item (A) the elements of item (B); had Congress intended for any of the elements of item (B) and not in item (A), such elements may not be utilized in the regulations to define the term "private patient". To do so would not only destroy what Congress intended as two alternative and mutually exclusive provisions, but would also violate the well-settled rule that an administrative determination as to the meaning of a particular statute may not go beyond the boundaries of the agency's delegated authority, must be consistent with such statute, and may not seek to alter the meaning of or enlarge the scope of such statute.

The proposed regulations would, in this regard, be contrary to the intent of Congress in enacting Section 227 of the Amendments. Section 405.521 (c)(1) of the proposed regulations in the first sentence thereof, states

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the exception of item (7)(A) of Section 227 of the Amendment, namely, that "In the case of physicians' services rendered during a hospital cost accounting period that began on or after July 1, 1973, where the hospital has or is participating in an approved graduate medical education program, payment on the basis of reasonable charges is applicable to the patient care services rendered to a beneficiary if the beneficiary is a private patient". This proposed regulation then states certain requirements which, if all are met, would give rise to a situation where a "private patient relationship" between a patient and his personal physician (as defined) would be "deemed" to exist. The requirement of chief concern to the Association is that of Section 405.521(c)(1)(iii) (and also Section 405.521(c)(3)(ii)) of the proposed regulations, which injects a "fiscal test" into the definition of "private patient relationship".

The most striking aspect of proposed regulation Section 405.521(c)(1)(iii) is its similarity to item (B) of Section 227. The requirements of this section of the proposed regulations would include billing, reasonable efforts at collection, and the existence of an obligation to pay with the existence of such obligation "demonstrated" by a 50 percent test (of collections from non-public sources). These elements of the proposed fiscal test, to be used in ascertaining the actuality of a private patient relationship, are basically the same as those of item (B) of Section 227 of the Act. The Association submits that it is contrary to congressional intent to use the requirements of item (B) of Section 227 in defining terminology in item (A) and that, in so doing, the Department of Health, Education and Welfare is exceeding its authority by seeking to enlarge and at the same time confuse the meaning and scope of Section 227.

Should this matter be considered by the courts, the question as to whether the Department of Health, Education and Welfare has exceeded its delegated authority in this regard may well be resolved solely on the basis of construction of Section 227, taking the statute on its face. However, a court may deem it necessary to consider the legislative history of Section 227, in which case the relevant observations in House Report No. 92-231 and Senate Report No. 92-1230 (the only components of the legislative history of Section 227 containing any material of pertinence) would be scrutinized. After reviewing this legislative history, the Association believes and so submits that Congress did not intend for a "fiscal test" to be among the criteria for determining whether a beneficiary is a "private patient", within the meaning of subparagraph (7)(A) of Section 227 of the Act, and that Congress intended items (A) and (B) of said subparagraph (7) to be separate exceptions.

Nothing in the House report speaks of actual payment or actual collection and no basis for a 50 percent test may be found therein. In fact, Congress has expressly confined the use of any such test to the exception of item (7)(B) of Section 227. Moreover, this legislative history indicates that what Congress was speaking of in this context was not any form of "fiscal test" but was a recognition of the fact that the private patient relationship

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between the patient and the physician commences when a contractual relationship between the two parties is initiated, that is, when the patient is legally obligated to pay for or to cause the payment for such services.

Discussion in the Senate report largely tracks the language of the House report and, therefore, comments on the House report are pertinent to this discussion as well. Of significance, however, is the fact that the Senate committee added a sentence in the first paragraph of the foregoing passage, in which a presumption is raised that all of the patients in a given setting are private patients where the institution offers "satisfactory evidence" that the "great majority" of patients pay for the physicians' services. However, this guideline, expressly interposed to "facilitate efficient administration", is only a presumption and is nether a conclusive presumption nor a rule to be wholly determinative of the question. This presumption -- which is absent in the House report -- may not be converted by the Department of Health, Education and Welfare into an absolute requirement, by means of regulations; but may -- at the most -- be reflected in the regulations as a mere presumption.

By developing this presumption and by making it a part of the pertinent legislative history, Congress has, the Association submits, merely taken notice of the fact that in most instances where a private patient relationship exists the physician is compensated by the patient or by a third party on the patient's behalf. Thus, the Congress has invoked a presumption of a private relationship where the factor is present -- to "facilitate efficient administration". However, Congress clearly avoided the taking of the position that a private patient relationship cannot exist absent collection by the physician of a fee for services. (Had Congress intended to take that position, the above referenced presumption would have no meaning and, in fact, would not have even been stated.) Thus, the intent of Congress underlying Section 227 does not warrant the imposition by the Department of Health, Education and Welfare of a fiscal test in proposed regulation Section 420.521(c).

The Association submits that a private patient relationship may exist between a patient and a physician where collection of a fee by the physician from the patient does not take place. To contend otherwise would be to exclude several recognized private patient relationships. For example, in paragraph (c)(2) under 405.521, the "private patient" relationship between a Medicare beneficiary and a consulting physician, pathologist or radiologist is effectively prevented unless the same status applies as to the personal physician or unless such consulting physician meets the requirements of paragraph (c)(1)(iii) of this section. These are unlawful restrictions on the options of the Medicare beneficiary that are specifically prohibited by Section 1802 of the Social Security Act. Furthermore, in the proposed regulations, the calculation to achieve the fifty percent level specifically excludes any payments from public medical assistance programs to be included

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(except Medicare where coinsurance and deductibles were substantially paid). This formula therefore makes the assumption that all Medicaid patients are nonprivate. There is no reference to the public/private sector dichotomy in the legislative history. It therefore appears arbitrary to exclude these payments where in fact they were, are or should be made.

The Association submits that a private patient is one who mutually with a physician assumes a professional relationship, where the physician simply assumes responsibility for professional care. As part of this relationship (in law, a contractual relationship), the patient may become legally obligated to pay for such care. However, the presence or absence of collection of a fee by the physician is irrelevant to the establishment of the requisite relationship; failure of collection does not destroy or preclude the private patient relationship.

Finally, in a number of institutions, there are agreements with state or local governments which specifically prohibited or presently prohibit fees being billed for specific groups of patients. It is discriminatory and arbitrary to set in motion a requirement which cannot be met simply because a given institution or group of physicians provide service to groups of patients under a state or county agreement. In other words, physicians and instituions in the future will be penalized not on the basis of the physician-patient relationship or the quality of care provided, but because of the economic status of the population they serve.

The Association believes there is a possibility that numerous undesirable and unrewarding situations might arise from implementation of the regulations as proposed. Our greatest concern in this area is that quality of patient care could be adversely affected. The fiscal test as well as the "setting" concept could serve as an incentive to maintain or foster dual systems of care -- one for private patients and one for nonprivate patients. Since the advent of Medicare, most teaching hospitals have made a definite effort to fully integrate patients without regard to ability to pay. These proposed regulations will prevent further progress in this area and may be an incentive for a social step backward.

The fiscal tests will be particularly discriminatory in "public" teaching hospitals which have been struggling to break their image as "charity organizations." This is specifically the case since it is extremely difficult for an institution to make the change from a cost based reimbursement to a fee for service charge when no coinsurance and deductibles are collected on the cost basis. Medicare patients apparently cannot be included in the effort to achieve the required 50 percent level.

There is an incentive for physicians to admit their patients to other institutions without teaching programs to avoid the regulations. This action would be detrimental to teaching hospital occupancy, detrimental to the educational programs, and detrimental to the relationship of these physicians with their respective teaching hospitals and medical schools.

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Further, implementation of these regulations could serve to discourage many of our most competent physicians from practicing in certain academic settings and could make recruitment of teaching physicians a most difficult task.

The requirement for a full review of the sources of payment for physician services, in order to determine if the necessary 50 percent level of patients paid the billed fees from sources other than public assistance programs, raises several problems. First, many institutions are not in a position to provide data, and many physicians will be rightfully unwilling to do so. (The Hospital Manual HIM-10 revision provides for alternate documentation under A 254.B 1, 2 and 3, but for one year only, and furthermore, most hospital accounts receivable systems will be unable to provide the data as required. Under such circumstances, it will be necessary to suggest that an acceptable sampling procedure be developed.) Second, the procedure calls for the data on a patient basis, when it would appear administratively desirable to accomplish the percentage calculation on a percent of gross charges, or on collections when this method is appropriate. Further, it will be very difficult to connect coinsurance and deductible payments to the Medicare payments in order to determine which Medicare patients or dollars may be included in the calculation to achieve the fifty percent level.

In defining a volunteer physician the regulations exclude from consideration the large number of physicians who are paid a nominal salary to teach a course in the medical school, supervise the teaching hospital's utilization review program or take responsibility for any one of a number of activities which do not include professional service to non-private patients. This would seem to be inconsistent with the statement in the proposed regulations that, "Such payments represent compensation for contributed medical staff time which, if not contributed would have to be obtained through employed staff on a reasonable basis." It is recommended that this sentence be reworded.

In the transmittal of a revision to the Hospital Manual HIM-10, it is stated that "Where the necessary coverage determination has not been made by the beginning of the teaching hospital's accounting period, the carrier will suspend reasonable charge reimbursement for physician services in the hospital until it is assured that payment is being made only for covered services in appropriate amounts." This is a very strong statement which in effect directs that payments be suspended immediately unless data is presently available to demonstrate otherwise. Such a directive is unreasonable since physicians and institutions have no way of determining what data will be required of them until final regulations are established.

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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.

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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.

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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

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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.

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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

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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

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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

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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

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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

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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

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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

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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

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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 <u>mixed bag</u>. 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*

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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 vested interests of its constituency.

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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:

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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

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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

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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

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(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.

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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 bio-medical 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?

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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?

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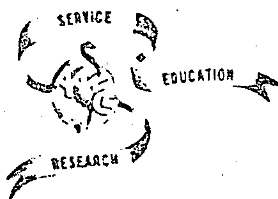

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

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

DATE July 26, 1973

TO: John Cooper; Marjorie Wilson

FROM: Jim Schofield

SUBJECT: Third Meeting of Various Agency Representatives with Staff of the Veterans Administration Regarding the Regulations and Program Guidelines for the Implementation of the VA Medical School Act; July 25, 1973

This meeting was attended by representatives of the Bureau of Health Manpower Education, the Osteopathic accrediting people, Glen Leymaster and myself representing the LCME and its parent associations, and two somewhat geriatric gentlemen who represented the VA special advisory group, i.e., Quigg Newton and Bob Felix, Dean, St. Louis School of Medicine.

Various questions and objections had been written in regarding the regulations as published in the Federal Register and practically all were accepted without major dispute.

Our three concerns were considered carefully and the expected result is that the regulations and/or guidelines would be modified to accommodate our concerns and interests. The first had to do with definition of faculty. It turned out that instead of VA fiscal contributions being restricted to those individuals whose "principle" duty is undergraduate medical education, what is intended is that the sum of salaries of those who are employed by a new VA medical school can be supported. In other words, the definition is quite broad instead of being exceedingly narrow as one would infer from reading the regulations.

The second and third of our concerns can be considered together since they are related to monthly expenditure reports and computation of indirect costs. It was pointed out that the VA should not attempt to reinvent the wheel, that the HEW had worked through this kind of thing with the schools in some detail, and that OMB circular #A-21 governing grants and contracts was a government-wide document with which the VA people should become familiar. (Apparently, the business folks of the VA were unaware of this significant document.) Monthly reports are an old custom for the VA to make to the Treasury Department; we insisted that annual reports -- as with HEW -- would do.

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There was considerable debate and concern about the definition of what educational institutions are eligible for VA grants under the law. The law, as written, cites "...colleges and universities engaged in a four-year program of undergraduate education..." It appears that the Medical University of South Carolina (Charleston) feels that it should be a recipient of one of the VA grants and protests this particular wording. The same is true of the College of Medicine and Dentistry of New Jersey which would like to establish a third medical school in Camden based in part upon VA resources. It is not clear to me what the VA will finally do. I think they will counsel with their political mentors and come up with something which would allow any and all comers to apply.

The law's wording requiring preference to veterans in the selection process of students for the new medical school was discussed at some length. Some of us were concerned that the law would require that the medical school, including those existing schools of medicine which have affiliated VA hospitals which would come in under subchapter 2 of the law, would have to give veterans preference when selecting all students to be enrolled in all programs in health education in the whole institution. After about an hour of discussion of this, it was decided that it was a highly legal question which has to be resolved before there could be any implementation by any existing college of medicine or university which has a broad spectrum of health education programs.

We had considerable discussion about what a Letter of Reasonable Assurance from the LCME is and how that might, under some very limited circumstances, differs from Preaccreditation status. On these matters, Bob Felix was helpful to us. (We had had an opportunity to prime him a couple of days before the meeting.)

The discussion followed the general route that an LCME Letter of Reasonable Assurance would in no way be necessary for an advocate of one of these new VA schools to apply. Rather, applications would be received by the VA following their own system, consultation would be held with staff of the AAMC-AMA LCME on a purely unofficial and nonbinding basis (this point was made very clear by me), that the LCME would consider sending its staff on a consultation site visit as has been the custom of the LCME for some time, but that no Letter of Reasonable Assurance of Accreditation nor Preaccreditation status could be granted until a full-scale site visiting team had been organized and dispatched by the LCME, ending in favorable action by the LCME. It took a little while to get these things over to the VA people, but I think they do appreciate the fact that the LCME is not prepared to have active consideration of 15 questions on Letters of Reasonable Assurance on as many prospective new institutions within the next several months.

There was some discussion of subchapter 2 (which allows money for expansion of existing medical schools now affiliated with VA hospitals - 88 of them) with the result that it is not yet known as to how the distribution of monies would be made between subchapter 1 (new schools) and subchapter 2 or subchapter 3 (allied health programs).

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We were told about the supplemental appropriation which is cleared by Congress contains $20 million of which $5 million was actually put into the 1974 budget in the expectation that only that smaller amount could be expended during fiscal 1974.

The VA requested the total of $75 million (and this is in the Senate version) for the fiscal 1975 appropriation, but it is expected that this may be reduced by the House below $50 million or perhaps as low as $30 million.

Late in the process Jim Muesser joined us, having left a session with the VA administrator concerning the 1975 budget proposals, to say that, after active discussion with the Congressman from the Milwaukee district and with the Chairman of the House VA Committee (Meadows) he had come to the conclusion that perhaps the law should be interpreted in such a way (under subchapter 2) that money could be granted to existing medical schools for the purpose of funding wholly new construction, to be done on Veterans Administration land. The obvious recipient is Marquette School of Medicine which is now an independent state supported operation which would like to relocate its facilities onto VA property, along with several other ancillary health programs which also desire relocation in Milwaukee.

Under subchapter 2, the existing medical schools affiliated with VA hospitals theoretically can get money to allow expansion of total medical student enrollment as contrasted to the HEW approach which concentrated on enlargement of the entering first year class. We pointed out that some of the schools might be interested in entertaining the possibility of increasing their total student body enrollment, provided incentives were adequate, and where the total cluster of resources, particularly clinical, could justify such an expansion. We mentioned that the quality of the American students studying in foreign medical schools has been improving noticeably and that our COTRANS program offered a system of quality control of these persons seeking transfer upon advanced standing back into the country; this could be considered as a source of students for "total enrollment" increases in existing schools under subchapter 2.

Muesser continues to insist that neither he nor anyone else really wanted this law, that it is something that members of the Legislative Branch devised and that they, the humble servants of the VA, must do their best to follow the wishes of the Congress.

JRS:kaj

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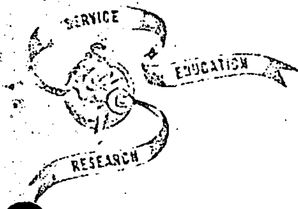

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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

WASHINGTON: 202: 466-5175

July 23, 1973

Administrator of Veteran Affairs
Veterans Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Sir:

This letter represents comments on behalf of the American Medical Colleges regarding the regulations and guidelines proposed for implementation of the Veterans Administration Medical School Assistance and Health Manpower Training Act of 1972 (Public Law 92-541), as published in the Federal Register, Volume 38, No. 123-- Wednesday, June 27 1973.

These comments are directed toward three perceived problem areas in the regulations and guidelines: (1) definition of faculty, (2) the requirement for monthly expenditure reports, and (3) the method of computation of indirect cost reimbursement.

1. Definition of faculty: Regulations (38 FR 16918, Section 17.402) definitions (f) (3). The term "faculty" is defined as "those individuals who have as their principal duties the instruction of students in the new medical school or the administration of the academic program of such a school." In an apparent reference to the same subject matter, the program guidelines (38 FR 16939 V.C.) contains the following note: "In this program the 'faculty' to whose salaries grant funds may be applied is only those individuals whose principal duties is the instruction of undergraduate students in the new school of medicine or osteopathy, or the administration of the academic program of that school."

Comment: If these definitions are narrowly construed, they could have the impact of severely restricting program development. It will be essential, for instance, to hire faculty members of many and varying disciplines in order to provide a full academic curriculum. In some instances it will undoubtedly be the case that a person essential to the undergraduate medical education program, and thus an indispensable member of the medical school faculty, will be required to spend less than a major portion of his time in the teaching of undergraduate students. These schools may, nevertheless, be required to pay 100% of the salary, since in most cases it will prove impossible to hire less

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than one full-time person for that role. Such a person, and there may be many in a given medical school, could under the definitions provided not be listed as a position to which grant funds could be applied. This may work an intolerable hardship on the school. On the other hand, such persons frequently contribute greatly to the mission of the institution through their involvement in the education of residents, fellows, and graduate students. Since the education of such individuals is considered an important element in the environment for undergraduate medical education, these activities contribute substantially to the undergraduate medical education process. We would, therefore, submit that such an interpretation would be unduly restrictive, and would inhibit program development.

Another interpretation of "principal duty" is possible, however. Such an interpretation would regard as an eligible faculty member any person who is on the faculty by virtue of his essential contribution to the undergraduate medical education process. We would argue for the appropriateness of the later interpretation, and would further urge that the definition be modified so as to make such an interpretation explicit.

Suggested revision: "Faculty" means those individuals essential to the undergraduate academic program of such a school.

2. Expenditure Reports. 38 FR 16940 XI; 16941 XII; 16943 XII.

Each of the above referenced provisions in the Guidelines require the grantee institution to submit monthly expenditure reports on the first working day of the succeeding month. This requirement is considered extremely impracticable. It is inconceivable that an institution would be capable of making a full accounting of its monthly expenditures on the first day of the succeeding month. Accounting and reporting mechanisms are not capable of producing the requisite information in such a time frame. Furthermore, we believe that monthly expenditure reports would prove a little utility to either the Veteran's Administration or the institution itself. The practice of the Department of Health Education and Welfare in both its grant and contract programs is to require annual expenditure reports. This reporting period has proved quite satisfactory to the institutions and has met the needs of the Department. We would commend to you the practice and the experience of the HEW and recommend that annual expenditure reports be substituted for the requirement for monthly reports.

3. Computation of indirect costs: 38 CFR Part 17 (38 FR 16917-20) 17.410 (b), with respect to indirect cost, states: "In the method of computation used, only indirect cost shall be included which bear a reasonable relationship to the program funded by the grant and shall

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not exceed a percentage greater than the total institutional indirect cost proposed is of the total direct salaries and wages paid by the institution." We are concerned that the handling of indirect cost proposed in these regulations will involve a new procedure not consistent with, and indeed in conflict with the government-wide procedures established by OMB Circular No. A-21 governing grants and contracts for research and for educational services. Circular No. A-21 is based on an averaging procedure which recognizes the impracticability of establishing relationships to any individual program. The procedure proposed here requires that such a relationship be drawn. In addition, it requires a comparison with total direct salaries and wages, which may not be the basis used in the calculation of indirect costs.

It is therefore suggested that the sentence quoted above be replaced by a reference to Circular No. A-21.

Program guidelines (38 FR 16937-44). Each of the guidelines included in this document contain a section entitled Indirect Cost. In the first instance, the guideline relating to the pilot program for assistance in the establishment of new state medical schools, indirect costs are limited to an amount not greater than 15% of the total amount awarded for faculty salaries in each award period. Each section further provides that these funds may be used by the grantee for cost which bear reasonable relationship to the purposes of the grant.

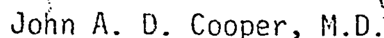
The 15% limitation is inequitable and discriminatory. Its impact on an institution will be determined by the design of its accounting system; many types of costs may be classified as direct in some institutions, and indirect in others. Any method of computing indirect costs reimbursement utilizing a percentage of direct costs will have an uneven impact on affected institutions.

We, therefore, suggest that the indirect cost section in each of the three guidelines be deleted, and be replaced by reference to OMB Circular No. A-21.

This entire matter is covered in greater detail in the comments to be submitted by the National Association of Colleges and Business Officers. We wish to associate ourselves with the comments and recommendations.

We shall appreciate your consideration of these suggestions and would be happy to discuss them further with you at your convenience.

Sincerely,



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