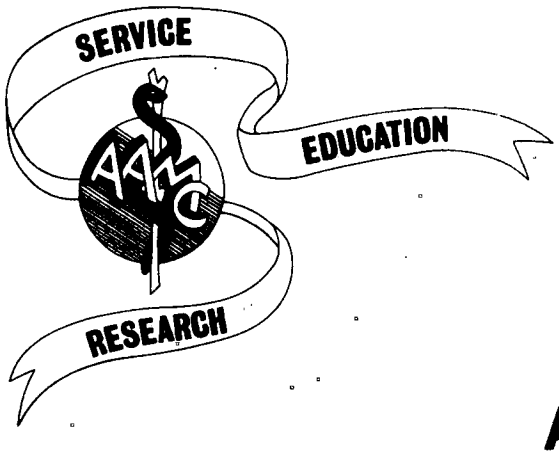

AGENDA
FOR
COUNCIL OF DEANS

ADMINISTRATIVE BOARD

WEDNESDAY, JANUARY 14, 1976

9:00 AM - 1:00 PM
WASHINGTON HILTON HOTEL
EDISON ROOM

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle, N. W.

Washington, D. C.

FUTURE MEETING DATES

COD Administrative Board ---------- January 14, 1976
Executive Council ---------- January 15-16, 1976

COD Administrative Board ---------- March 25, 1976
Executive Council ---------- March 26, 1976

COD Administrative Board ---------- June 24, 1976
Executive Council ---------- June 25, 1976

COD Administrative Board ---------- September 16, 1976
Executive Council ---------- September 17, 1976

COD SPRING MEETING ---------- April 25-28, 1976
Belleview Biltmore Hotel
Clearwater, Florida

COUNCIL OF DEANS
ADMINISTRATIVE BOARD
January 14, 1976
9 a.m. - 1 p.m.
Washington Hilton Hotel
Edison Room

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

September 18, 1975
9 a.m. - 1 p.m.
Monroe Room East
Washington Hilton Hotel

PRESENT

(Board Members)

Ivan L. Bennett, Jr., M.D.
J. Robert Buchanan, M.D.
Ralph J. Cazort, M.D.
Christopher C. Fordham III, M.D.
Neal L. Gault, M.D.
John A. Gronvall, M.D.
Andrew D. Hunt, M.D.
Julius R. Krevans, M.D.
William H. Luginbuhl, M.D.
Robert L. Van Citters, M.D.

(Guests)

Mark Cannon, M.D.
Cynthia B. Johnson, Ph.D.

(Staff)

Gerlandino Agro
Robert J. Boerner
Perry D. Cohen
George R. DeMuth, M.D.
Hilliard Jason, M.D.
H. Paul Jolly, Ph.D.
Joseph A. Keyes
Susan R. Langran
Diane Mathews
Jaimee S. Parks
Emanuel Suter, M.D.
Marjorie P. Wilson, M.D.

I. Call to Order

The meeting was called to order at 9:00 a.m. by Dr. Ivan L. Bennett, Jr., Chairman.

II. Minutes of the Previous Meeting

The minutes of the June 19, 1975 meeting were approved as written.

III. Executive Council Actions

A. The Role of the FMG

The report on "The Role of the Foreign Medical Graduate" approved by the Coordinating Council on Medical Education on June 5, 1975 was sent to members of the Executive Council for preliminary review and comment.

In general, the responses were favorable regarding most aspects of the report and its recommendations; but some reviewers warned against the overextension of institutional resources and they expressed concern about the control of quality of proposed programs. Support was given to the concept that the United States should be self-sufficient in the scope of its programs for physician education, and that solutions for domestic health service problems should not depend upon the immigration of FMGs. Similarly, the importance was stressed of having high admission standards for FMGs into graduate programs in the United States comparable to those for U.S. graduates and of having high quality educational opportunities for accepted FMGs. Strong support was also given to the recommendation that the original purpose of the exchange visitor program be reestablished, and some felt that teaching hospitals be included as approved sponsoring institutions for such programs in addition to accredited medical schools.

The two items which received the most criticism were the recommendation for the development of remedial programs for resident FMGs who have failed to qualify for ECFMG certification or licensure and the recommendation that the Fifth Pathway be utilized as a mechanism for entry of U.S. citizens studying medicine abroad. It was also stressed that the State Department should not overcommit United States medical institutions in an attempt to reach agreements with other countries trying to train physician manpower. Ultimately, the final decision in the United States for the initiation of an exchange program must rest with the American institution.

The appropriateness of specific recommendations regarding training requirements for licensure of both U.S. and foreign medical graduates was questioned because they are not germane to this document and because the CCME does not have authority or power of enforcement.

Dr. Emanuel Suter, Director, Division of International Medical Education was on hand to discuss the document presented for Executive Council consideration.

The staff recommended approval of the report with the exception of the sections referring to 1) the initiation of remedial programs for hitherto unqualified resident FMGs and 2) the Fifth Pathway. The staff also recommended that the letter of conveyance to the CCME of the Council action indicate AAMC disapproval of the policies implicit in these sections. Dr. Suter commented on the staff

recommendations noting strong feeling that there are probably higher priorities in U.S. medical schools than initiating remedial programs for foreign students who repeatedly fail to qualify for licensure. Dr. Suter also suggested that the Fifth Pathway is an undesirable approach to handling the problem of U.S. citizens who have studied abroad and wish to practice in the U.S. It does not result in the award of the M.D. degree and does not qualify the participant for licensure in many states which require either: 1) ECFMG certification or 2) an M.D. degree from an accredited U.S. medical school, thus making it impossible in some states for them to be licensed. Furthermore, the Fifth Pathway has created a disturbing element in some states by opening the legislature to considerable pressure to change the policy on licensure to include these students as eligible persons, which in a way threatens a reasonably well-proven system of controls. Staff recommended that the AAMC adopt at least an internal policy on the Fifth Pathway, for the counsel and assistance of its member institutions.

The question was asked of the staff in regard to whether the sponsoring agencies have a line item veto in the CCME, which would mean that the recommendations of the Council to except those sections of the report would have to be heeded. Dr. Marjorie Wilson stated, with the support of Dr. Julius Krevans, that that was, indeed, the case.

Action:

The Board recommended Executive Council approval of the report on the Role of the Foreign Medical Graduate of the Coordinating Council on Medical Education excepting the following:

--Recommendation B-11 which states:
"That on an interim basis special programs of graduate medical education be organized for immigrant physicians who have failed to qualify for approved residencies and who have immigrated to this country prior to January 1, 1976. [This time restriction does not apply to physicians entering the U.S. with Seventh Preference visas (refugees).] Immigrant physicians applying to such programs must present credentials acceptable to the sponsoring schools; the purposes of these special programs are:

a. to provide a proper orientation to our health care system, our culture and the English language, and

b. to identify and overcome those educational deficits that handicap FMGs in achieving their full potential as physicians in the U.S. health care system;"and

--Recommendation C-6, which states:

"That U.S. medical schools continue to offer on a voluntary and temporary basis to qualified U.S. nationals who have studied medicine abroad and have completed all of the formal requirements of the foreign medical school except internship and/or social service, an academic year of supervised clinical training (The Fifth Pathway Program) prior to entrance into the first year of approved graduate medical education."

The Board further recommended that the letter of conveyance of the Council's decision to the CCME indicate the judgment that these were matters of policy, not mere editorial suggestions.

B. U.S. Citizens Studying Medicine Abroad

The Executive Council agenda contained a four-page report on the status of U.S. citizens studying medicine abroad with two tables appended. The first table specified the experiences over the past 5 years of such persons re-entering the United States and the profession of medicine via: 1) ECFMG certification; 2) COTRANS; 3) Fifth Pathway. The second table displayed information relating to states permitting licensure of Fifth Pathway physicians and U.S. medical schools offering or contemplating Fifth Pathway programs. The paper described problems and issues associated with these phenomena and offered the staff recommendation for an Executive Council policy statement.

Dr. Hunt objected to the pejorative tone of the statements relating to foreign-trained physicians and expressed his view that the document requires the addition of paragraphs emphasizing the positive contributions made by foreign-trained physicians and their particular capabilities for serving certain of our foreign-speaking populations. Dr. Buchanan referred to a report of the New York Regents emphasizing the state's needs for more physicians. He predicted that unless we had appropriate alternatives, the proposed policy statement would be viewed as self-serving and received hostilely. Dr. Gronvall pointed out the general nature of the first recommendation and the difficulties associated with implementing the operational portions of the second. Dr. Luginbuhl indicated his concern that in the absence of a generally accepted target for the production of physician manpower we will be constantly vulnerable to criticism if we take positions which will have a limiting

effect. Dr. Krevans expressed the view that at the present time there is no appropriate statement that can be made. We are vulnerable if we criticize the influx of foreign-trained physicians and programs which facilitate it, but we cannot morally support programs which are not good programs. A system which would work best puts responsibility on the individual school but this may not be politically tenable at the present time. He opposed any efforts to set national academic standards. Dr. Bennett felt that if such a statement were adopted, the AAMC would lose all credibility in New York.

Action:

The Board acknowledged the importance of the subject of U.S. citizens studying medicine abroad, but did not believe that the two statements offered for its approval are appropriate for adoption by the Association at this time.

C. LCME Procedures for Levying Charges To Schools for Early Stage Accreditation Site Visits and Provisional Accreditation

The LCME, in June 1975, acted to levy charges to medical schools seeking initial Provisional Accreditation as well as a Letter of Reasonable Assurance for federal support as a developing medical school. The parent Councils, in June 1973, approved levying charges for Provisional Accreditation but not for a Letter of Reasonable Assurance. In both situations, the cost to the school would include the full cost of the travel to and housing on site of the four to six survey team members and a flat fee of $1,000. This action is not to be construed as inhibition of the long standing practice of providing staff consultation to a new program at LCME expense, at the initiative of the LCME or its senior staff members.

Action:

The Board endorsed Executive Council approval of the principle that the LCME levy charges for Letter of Reasonable Assurance site visits to developing medical schools.

D. LCME Voting Representation of the Canadian Medical Schools

In October 1974, the LCME considered the desirability for greater participation in the accreditation process by the Association of Canadian Medical Colleges, which now represents sixteen colleges of medicine accredited by the LCME. The LCME Chairman discussed with the President of the Executive Committee of ACMC the feasibility of appointing a Canadian voting representative to the LCME. The Executive Committee, ACMC, in its meeting of May 1975, appointed Dr. R. Brian Holmes, Dean of the University of Toronto Faculty of Medicine to be the voting Canadian representative.

Action:

The Board endorsed Executive Council approval of the seating of a representative of the ACMC as a voting member of the LCME.

E. 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:

University of South Florida
College of Medicine

Southern Illinois University
School of Medicine

Action:

The Board endorsed Executive Council recommendation of election by the Assembly of the University of South Florida College of Medicine and the Southern Illinois University School of Medicine to Institutional Membership in the AAMC, contingent upon ratification by the full Council of Deans.

F. Amendment of the AAMC Bylaws to Establish a Category of Corresponding Members

At its last meeting the Executive Council approved the Report of the COTH Ad Hoc Membership Committee, recommending that a category of Corresponding Members be established. It was specified that each of the three Councils would be able to nominate Corresponding Members within the criteria developed by the Councils and approved by the Executive Council. It was also recommended that Corresponding Membership dues be set at $500 per year, and that an absolute requirement for

becoming a Corresponding Member would be ineligibility for any other class of membership in the Association.

Corresponding members would have not voting participation in the Association affairs and the governing structure of the AAMC would remain unchanged. Corresponding members would receive notification of all open AAMC meetings, as well as certain specified AAMC publications and communications (e.g. Journal of Medical Education, President's Weekly Activities Report, other appropriate publications and memoranda.)

The following additions to the AAMC Bylaws were proposed:

Title I, Section 1, Paragraph I:

I. Corresponding Members - Corresponding Members shall be schools, organizations, hospitals or other institutions (in the United States) which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

Title I, Section 3, Paragraph F:

F. Corresponding Members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies, or Council of Teaching Hospitals.

Because of reservations regarding the use of the term "member" as applied to institutions which do not meet the criteria of the Executive Council for Association membership, but which wish to keep on top of developments in the Association, the Board took the following actions.

Action:

The Board suggested that the proposed amendments of the AAMC Bylaws be modified to read as follows:

Title I, Section 1, Paragraph I:

I. Corresponding Members - Corresponding Members shall be hospitals involved in medical education (in the United States) which do not meet the criteria established by the Executive Council for membership in the Council of Teaching Hospitals.

Title I, Section 3, Paragraph F:

F. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals.

Action:

The Board also recommended the establishment of the subscriber service which would make available for a set fee AAMC publications and mailings.

G. Report of the National Health Insurance Review Committee

At its April meeting, the Executive Council requested that the Chairman appoint a small Review Committee to recommend appropriate action on a national health insurance policy statement which had been forwarded for consideration by the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education. The Committee was also requested to recommend appropriate additions or modifications to the existing AAMC National Health Insurance Policy in accord with the recommendations to the CCME LCGME.

An oral Committee Report was presented at the June Executive Council meeting by David Thompson, M.D. After brief discussion, the Executive Council voted to table the Committee Report until its September meeting so that a written report could be formally included in the meeting agenda.

Dr. Mark Cannon questioned the deletion of the LCGME/CCME Recommendation regarding the consideration of residents and clinical fellows as part of the medical staff of the teaching institution. Dr. Buchanan, as a member of the Review Committee, explained that the Committee felt that the institutions have the right to establish their own definitions of medical staff of the teaching institution. He also pointed out that such definitions are quite often subject to the approval of outside agencies.

Action:

The Board recommended Executive Council approval of the Committee report which is appended to these minutes.

H. Recognition of New Specialty Boards

The recognition of new specialties to permit their developing certifying boards and accreditation programs for residencies has historically been the responsibility of the Liaison Committee for Specialty Boards (LCSB). The ABMS and the Council on Medical Education of the AMA have equal membership on this Committee. Final action on the recommendations of this Liaison Committee has been the prerogative of the House of Delegates of the AMA and the membership of the ABMS.

With the foundation of the Coordinating Council on Medical Education and the LCGME, it appears logical that decisions regarding the formation of new certifying boards and accredited residency programs for a hitherto uncertified and unaccredited specialty should be the responsibility of the Coordinating Council with concurrence of its parent organizations. This is important because the growth of specialties has an impact upon all the member organizations of the Coordinating Council and has serious implications for the public interest.

An ad hoc committee was established by the Coordinating Council and the Liaison Committee on Graduate Medical Education in the Spring of 1975 to study this matter. This Committee has had two meetings. The second of these was with the LCSB. The Committee has made no recommendations and appears to be unsettled as to its charge. Meanwhile, the House of Delegates of the AMA has approved a set of standards developed by the Council on Medical Education for residency training in emergency medicine.

Dr. Krevans was concerned with the phrase indicating that all parent organizations of the CCME must be in on the approval process for the development of new specialties. While he made it clear that his intention was not to promote the rapid addition of new specialties, he expressed the concern that the process of approving new specialties be an expeditious one and did not see this happening by going through the parent organizations. While rules of the CCME require approval of the parent organizations on all policies in this case that requirement might best be left unemphasized to permit the development of some flexibility in the future.

The Board voted to recommend deleting the phrase "and its parent organizations."

Action:

The Board recommended that the following statement (with indicated phrase deleted) be sent to the Coordinating Council on Medical Education and its member organizations as a position of the Executive Council:

"The Executive Council of the Association of American Medical Colleges believes that the authorization of the formation of new specialty boards and the development of accreditation programs for new specialties must be the responsibility of the Coordinating Council on Medical Education ~~and its parent organizations~~. The Coordinating Council, in conjunction with the Liaison Committee on Graduate Medical Education, should establish specifications and procedures for, the authorization of the development of new specialties certifying boards and residency accreditation programs."

I. Modification of "Recommendations of the AAMC Concerning Medical School Acceptance Procedures"

The Early Decision Plan (EDP) permits a medical school applicant to file a single application (usually prior to August 15) and guarantees that the applicant will receive a prompt decision by that school (usually on or prior to October 1). In 1973-74 EDP reduced the total number of applications by approximately 5000 and in 1974-75 by approximately 6500, thereby lessening the admission burden of all medical schools.

Regardless of whether all medical schools participate fully in the Early Decision Plan, this program is deemed beneficial by the 59 schools which do currently participate. The establishment of a uniform first date for notification of acceptance among all medical schools, whether participating in EDP or not, strengthens EDP for those schools which do find it useful in the following respects: (1) Assures that EDP applicants who are not accepted have the opportunity to apply to other schools before any acceptances are offered or any places are filled; and (2) Assures that EDP applicants will be notified of action on their applications well in advance of notification to non-EDP applicants.

In recognition of these facts the Group on Student Affairs (GSA) has endorsed the following statement and recommends that it be inserted as procedure number 2 in the "Recommendations of the AAMC Concerning Medical School Acceptance Procedures":

Each medical school should agree not to notify its applicants (except for those applying via EDP) of acceptance prior to November 15 of each admission cycle.

Action:

The Board endorsed Executive Council approval of the recommendations of the GSA Steering Committee.

J. Planning Agency Review of Federal Funds Under the Public Health Service Act Titles IV and VII

At its April meeting, the Executive Council appointed a special task force to review the new Health Planning and Resources Development Act of 1974, P.L. 93-641. The task force, chaired by Charles A. Sanders, M.D., General Director of Massachusetts General Hospital, was charged with the responsibility for identifying the particular issues which require AAMC attention and providing guidance to AAMC staff. On May 22, 1975 the task force held its first meeting.

The following document was prepared by the task force in response to a request from HEW's Bureau of Health Resources Planning and Development. It represents the task force's comments on the interpretation of the section of the law pertaining to planning agency review of proposed uses of Federal funds under Title IV (Research) and Title VII (Health Manpower Training). Due to the timeliness of the issue and the need for AAMC input to be received during the preliminary regulation development process, the paper has been submitted to Eugene Rubel, Director of the Bureau of Health Planning and Resources Development.

Action:

The Board recommended that the Executive Council approve the task force report. It further recommended that the matter be fully discussed at the Executive Council meeting, so that the grave implications of this legislation be fully recognized.

K. Recovery of Medicaid Funds and Sovereign Immunity

The 11th Amendment and the doctrine of sovereign immunity bar the exercise of the judicial power of the United States (any action in federal courts) in any suit against a state prosecuted without the state's consent. There is no bar, however, to such a suit seeking a court order requiring a state of its officials to comply with or cease violating federal law. This has resulted in an anomalous situation in the case of state participation in federal welfare programs. A claimant may sue to assert his rights to future benefits, but he may not receive redress for the denial of past benefits unlawfully withheld. (Edelman v. Jordan)

This matter has relevance to the Association because at least one of its members has a claim against a state for reimbursement for services delivered under the Medicaid program which the state refuses to pay. The law in its current posture bars litigation of this claim which amounts to over several millions of dollars.

S.1856 introduced by Senator Taft with Senators Stevenson, Percy, Case, McGovern and Gravel, is designed to remedy this situation by imposing, as an express condition to a state's participation in a federal welfare program, a requirement that the state waive any immunity it may enjoy from a suit brought by or on behalf of any claimant for aid or assistance under such program or for redress for violation of any other requirement of federal law relating to such program. The Association has been asked to support actively the enactment of S.1856.

On the one hand this would appear to be of direct interest and benefit to our member institutions. It would permit them to seek adjudication of their claims and cuts off the ability of state to shirk their responsibility. On the other hand, the Association has consistently opposed the federal government's exploitation of its spending power to achieve indirectly objectives which would be precluded by the Constitution if attempted directly (e.g. mandatory service, uniform curriculum, enrollment increases).

At this point in the meeting, Dr. Gronvall assumed the chair for Dr. Bennett, who had a conflicting engagement. Mr. Keyes elaborated on the involvement of the particular member institution in this situation. The concern was raised as to how far the Association should go in taking a stand on such a constitutional question. It was agreed that the AAMC should speak to the issues in which it has expertise and support its constituent institutions and that perhaps the Association should pursue further knowledge of the broader implications of such legislation. It was agreed the AAMC should take no stand on this legislation at this time.

Action:

After consideration and discussion of the matter, the Board expressed its belief that institutions should be reimbursed for services delivered by them and that some way of accomplishing this should be established. However, the Board expressed its lack of expertise on the broader implications of the proposed legislation and recommended that the Association take no stand on it.

IV. ADMINISTRATIVE BOARD ACTIONS

A. Nomination of Distinguished Service Members

A committee consisting of J. Robert Buchanan, Chairman, Robert L. Van Citters, and Christopher C. Fordham, solicited the Council of Deans for recommendations for nominations to Distinguished Service Membership. On the basis of the responses and their own deliberations the following names were proposed for Board action:

Lewis Thomas
Leon Jacobson
George Aagaard
Donald Anderson
Stanley Olson
Clifford Grulee
William Mayer

Dr. Buchanan disclosed that several persons who were currently Emeritus Members were proposed for Distinguished Service Membership by the Council Members. The committee concluded that because election to Emeritus Membership accorded equal honor and because Distinguished Service Membership was designed to facilitate the continuing participation in the governance of the AAMC of those who had served the AAMC while a member of a Council, but are no longer eligible by virtue of a change in their institutional status to do so and because Distinguished Service Members automatically become Emeritus Members at age 70, these persons should not be nominated to Distinguished Service Membership.

Action:

The COD Administrative Board recommended the above mentioned persons be nominated by the Executive Council for election to Distinguished Service Membership.

B. COD Guidelines for OSR

At its January 15, 1975 meeting the Board rejected a proposed amendment to the OSR Rules and Regulations which would specify that "only students may vote in the selection [of OSR Representatives at the institutional level]". This amendment was rejected in part because it appeared to conflict with the COD Guidelines for the OSR which provided that the process of selection should "facilitate representative student input and be appropriate to the governance of the institution".

It was the opinion of the Board that the COD should not mandate a change in existing institutional provisions for the selection of OSR representatives. One member suggested that the effect of this modification might be that the OSR would lose representation from the schools who do not select representatives solely on the basis of student vote.

The Board voted to maintain the wording as stated in the Guidelines and disapproved the OSR revision. It did, however suggest that the section in the Guidelines referencing OSR selection might be revised to indicate a COD preference for student selection of OSR representatives, which would stop short of making it a requirement for OSR representation.

On reflection, it appeared to staff that it might be wise to retain the character of the Guidelines as an historical document for setting forth the ground rules for the establishment of the OSR, modifications to these expectations might best be reflected by other means. One such means is, of course, the approval of Rules and Regulations amendments.

A device which might best accomplish the Board's purpose may be the formulation of a resolution interpreting the intent of the guidelines which the Board would recommend for adoption by the Council of Deans at its annual meeting.

The following recommendation was presented to the Board for its review and subsequent submission to the COD:

"The Council of Deans reaffirms its intention that students play a major role in the selection of institutional representatives to the Organization of Student Representatives. The Guidelines for the Organization of Student Representatives adopted by the Council of Deans on May 20, 1971 expresses this intention in the following manner:

'A medical student representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will facilitate representative student input and be appropriate to the governance of the institution.'

While the Council is unwilling to mandate a particular method of student selection, it reaffirms the view that the appointment of the representative by the dean acting alone or by a committee in which the students do not have a major voice, or by any other means which preclude substantial student participation is inappropriate to the objectives of the AAMC in establishing the OSR. It is intended to be a vehicle for representative student input into the deliberations and decisions of the AAMC."

Dr. Mark Cannon, OSR Chairperson offered an amendment to the resolution which would state that the "students play the major role" in selecting OSR representatives, rather than "a major role". Dr. Cannon subsequently informed the Board that his recommendation of amendment to the resolution was not carried to the COD Administrative Board by a vote of the OSR Administrative Board. The OSR Board approved the resolution as it stands, but, Dr. Cannon reported, did so with expression of the belief that a proposed change in wording would not be viewed favorably by the COD Board. He, thus offered his recommendation as Chairperson of the Organization acting in what he perceived to be the best interest of his constituency.

The chief issue raised by the Board with respect to this suggested amendment was the role of the AAMC in influencing institutional governance. The consensus was that a method for the selection of representatives should not be dictated to the constituent institutions.

Action:

1. On the proposal to amend the resolution to state: a) that the students play "the major role" in the OSR representative selection process; and b) that the word "intention" in line 1 be changed to "view", the vote was 4 in favor and 4 opposed; the amendment was defeated.

2. On the resolution as written: the motion was carried with one dissent.

C. Survey of Medical Student Liability Insurance Coverage

At its last meeting, the Board recommended that the AAMC survey the Council of Deans to develop data regarding the extent to which institutions retain liability coverage for their students.

A draft questionnaire was developed by the Division of Student Programs with the Division of Institutional Studies and has been reviewed by the GSA Steering Committee.

The Board was requested to review the questionnaire to determine whether it met the Board's expectations.

In addition to several editorial corrections, the Board had two major suggestions: 1) that "moonlighting" be expanded to include free clinics or organizations which have not part in the teaching program of the institution; 2) that certain questions be clarified to remove ambiguities relating to whether the question was directed to gathering information about coverage of the student or the institution providing the coverage.

D. Implementation of the AAMC Data Release Policy

The Association staff is now in the process of implementing the policy for the release of AAMC information, beginning with the data currently filed in the Institutional Profile System (IPS).

The Institutional Profile System of the AAMC is a computer-based information system that can provide data on a wide variety of subjects, such as sources of medical school revenues and expenditures, statistics on faculty manpower, student enrollment, attrition, ethnic and sex composition, medical school curricula, facilities and so on.

The data are provided to the AAMC by the medical schools through questionnaires such as:

Liaison Committee part I (financial)
Liaison Committee part II (Institutional)
Faculty salary survey
Curriculum directory
Fall enrollment
Health service delivery and primary care
DHEW facilities survey
Faculty roster

The Institutional Profile System includes data from the most current questionnaires and publications, and also data from preceding years, thus providing the capability for analysis and for time-series studies.

The information stored in IPS has so far been treated as privileged for use by the Association's staff only. Data from IPS have been released outside the Association in aggregate form, but with all possible safeguards to preclude the identification of any individual institution's data, except in those instances when the information is already public knowledge through publications and/or public records.

During the last two years, there has been substantial progress toward the development of an orderly approach to the release of AAMC data to the Association's constituents and to the general public. The Association has adopted a policy for the release of information derived from its databank.

That policy provides for the following classification of information:

"Data in the possession of the Association will be classified according to permitted access using the following categories:

I. Unrestricted - may be made available to the general public.

II. Restricted - Association confidential -- may be made available to member institutions and other qualified institutions, organizations and individuals subject to the discretion of the President.

III. Confidential - A) Institutional - Sensitive data collected concerning individual institutions generally available only to staff of the Association; and B) Personal - Sensitive data collected from individual persons generally available only to staff of the Association. It may be released with permission from the individual.

No information will be released which could be identified with an institution unless reported or confirmed by that institution."

The Data Development Liaison Committee (DDLC) reviewed the recommendations of staff regarding the release categories to be assigned each of the IPS variables. The Administrative Board in turn reviewed the recommendations of the DDLC and endorsed the vast majority of that committee's judgments. The Board devoted particular attention to the following areas.

1. Variables pertaining to the Health Service Delivery and Primary Care questionnaire: the Board concurred in the committee's judgment that these should be listed as "unrestricted".

2. Variables pertaining to medical college revenues and expenditures from LCME Questionnaire, Part I: the Board concurred in the committee's judgment that 3 items relating to total revenues (1120-1122) should be listed as confidential, but recommended that 24 others (1094-1119 and 1123-1137)--specified categories of revenues and expenditures--be classified as restricted rather than unrestricted as the committee advised.

3. Variables relating to funds for construction by source and building data (1935-1954) from the LCME Questionnaire, Part II and variables related to medical student admission, retention and graduation by ethnic background (2131-2148): the Board disagreed with the committee's advice that these should be unrestricted and recommended that they be classified as restricted.

4. Variables pertaining to the ethnic and sex grouping of repeaters and withdrawn students (1462-1497): the Board agreed with the half of the committee that regarded these data as sensitive, but recommended that they be classified as confidential rather than restricted.

5. Variables relating to the reasons for student withdrawal (1520-1529): the Board, with two members abstaining concurred with the committee's judgment that these items should be classified as restricted.

The deliberations were in part devoted to a discussion of the impact of the classification scheme. It was emphasized that the matter at issue was the extent to which institution specific information would be released with institutional identification. All data, according to the policy statement, is subject to release in aggregate form. Unrestricted is subject to release in institution specific form, without prior clearance. Restricted information is subject to release at the discretion of the AAMC President to member institutions and other qualified institutions, organizations and individuals. Confidential information may be released only with the permission of th institution or individual to whom it pertains.

The Board, with 2 members of the opposite persuasion took the stance that much of the information under review as discussed above was sufficiently sensitive that it should be handled with discretion. It therefore suggested that on matters judged to be sensitive, a more restrictive classification was warranted. In addition, the Board indicated its intention to devote further consideration to this important area, particularly the staff procedures for handling requests for data.

V. DISCUSSION ITEM

Dr. Hilliard Jason of the AAMC staff came before the Board to discuss a draft paper called "Promotion Decisions in Medical Schools" generated by data gathered by means of an exercise conducted at the 1975 COD Spring Meeting. Dr. Jason was anxious to receive COD input on the advisability and desirability of publishing such a paper. While one or two members of the Board believed they would be comfortable with a paper defining conclusions of that exercise, the majority of the Board expressed the following concerns:

1. The implied contract regarding this section of the meeting was that it was to be an exercise from which deans might learn something regarding the process of making good decisions. Participation of the deans was on this basis rather than with the purpose of gathering data.

2. It was suggested that the design of the exercise made it appropriate for its intended purpose but possibly inappropriate as the basis for a study.

3. The planning of future COD programs could be hampered if such a paper were published in light of the first two concerns.

Dr. Jason thanked the Board for its advice and stated his intention to abandon plans for publishing the paper as an independent study.

VI. ADJOURNMENT

The meeting was adjourned at 1:00 p.m.

APPENDIX I

COD BOARD MINUTES

9/18/75

NATIONAL HEALTH INSURANCE

REVIEW COMMITTEE REPORT

Pursuant to its charge the Committee reviewed the Report of the CCME/LCGME Committee on Financing Medical Education and the Impact of National Health Insurance on Medical Education. Attachment I outlines the CCME/LCGME Summary of Recommendations. Attachment II represents a point-by-point critique and reformulation of the CCME/LCGME recommendations. The Committee recommends that the Executive Council approve the reformulation of the seven CCME/LCGME recommendations which have been reduced to the four recommendations as presented in Attachment III as the Executive Council response to the CCME/LCGME Report.

The Committee was also requested to examine the existing AAMC policy on National Health Insurance to determine if theCCME/LCGME recommendations should stimulate any revision of that policy. Of the ten-point summary statement of the Task Force Report appearing as Attachment IV, the Committee believes that the two items concerned with Provider Reimbursement Standards (Item VII) and the Role of Philanthropy (Item X) should be highlighted in any forthcoming AAMC policy statement on National Health Insurance. The Committee also believes that the Task Force Report, with these items highlighted, together with the recommended modifications of the CCME/LCGME Report provide an appropriate basis for Association response to inquiries such as that of Congressman Rogers of June 2, 1975.

Charles B. Womer, Chairman
Robert Buchanan, M.D.
Thomas R. Johns, M.D.
David D. Thompson, M.D.
Phil Zakowski

ATTACHMENT I

CCME/LCGME COMMITTEE ON NATIONAL HEALTH INSURANCE AND FINANCING MEDICAL EDUCATION

SUMMARY OF RECOMMENDATIONS

At its meeting of March 10, 1975, the Committee agreed to present the following recommendations to the Coordinating Council on Medical Education:

1. For the purpose of reimbursement under National Health Insurance, the cost of approved programs of graduate medical education in teaching institutions shall be included in the overall "cost of doing business." The cost of graduate medical education shall not be divided into cost for service, cost for education, and cost for teaching. The "cost of doing business" shall include the recompense of residents, payment to supervisors and teachers, and cost of facilities, including space and equipment.

2. Graduate medical education in all its aspects shall be provided for within health insurance premiums.

3. All individuals (defined as residents and clinical fellows providing patient care) involved in graduate medical education shall be considered part of the medical staff of the teaching institution under the bylaws, rules and regulations of that institution.

4. The manner in which residents are paid shall be left to local option. Options may include:

   a. Payment of stipend or salaries to residents within hospital budgets;

   b. Payment to residents, out of fees earned for direct service to patients in accordance with the participation of residents in the practice plan of the teaching institution.

5. A national health insurance system should provide support for residents and development of programs in graduate medical education.

6. A national health insurance system should provide support for modification of programs in graduate medical education through the appropriate expansion of existing programs, the addition of

needed new programs, or the elimination of programs which no longer fit the aims of education or needs of patient care.

7. Any system of national health insurance should provide for ambulatory patient care. The recommendations 1-6 shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of graduate medical education in the ambulatory setting, including facilities, space and equipment, as well as personnel.

The major impact of national health insurance will be on graduate medical education. It is the consensus of the Committee that undergraduate medical education will be secondarily affected. The implementation of the recommendations for graduate medical education would assist in the improvement of undergraduate medical education by providing increased support and facilities, as well as teachers and supervisors for undergraduate medical education.

ATTACHMENT II

LCGME/CCME Recommendation #1

For the purpose of reimbursement under national health insurance, the cost of approved programs of graduate medical education in teaching institutions shall be included in the overall "cost of doing business." The cost of graduate medical education shall not be divided into cost for service, cost for education, and cost for teaching. The "cost of doing business" shall include the recompense of residents, payment to supervisors and teachers, and cost of facilities, including space and equipment.

Review Committee Recommendation

For purposes of reimbursement under national health insurance the costs of approved programs of clinical post-doctoral education in teaching institutions shall be included as an allowable cost (a cost of doing business). The allowable costs of graduate medical education include, but are not limited to, the recompense of clinical post-doctoral trainees (interns, residents and fellows), payments to supervisors and teachers, and are applicable to both inpatient and outpatient services as well as the cost of space, equipment and supplies. Revenue from grants, endowments and other available sources applicable to clinical post-doctoral medical education should be deducted from total cost prior to determining reimbursable cost. The manner and amount of compensation for clinical post-doctoral trainees should be left to local option.

LCGME/CCME Recommendation #2

Graduate medical education in all its aspects shall be provided for within health insurance premiums.

Review Committee Recommendation

The recognition of the costs of approved programs in clinical post-doctoral education as an allowable cost shall be acknowledged and paid by all purchasers of health care services whether governmental or private.

LCGME/CCME Recommendation #3

All individuals (defined as residents and clinical fellows providing patient care) involved in graduate medical education shall be considered part of the medical staff of the teaching institution under the bylaws, rules and regulations of that institution.

Review Committee Recommendation

This recommendation should be withdrawn.

LCGME/CCME Recommendation #4

The manner in which residents are paid shall be left to local option. Options may include:

(a) payment of stipends or salaries to residents within hospital budgets;

(b) payment to residents, out of fees earned for direct service to patients in accordance with the participation of residents in the practice plan of the teaching institutions.

Review Committee Recommendation

The final two sentences of substitute recommendation #1 serve the purpose of this statement. Therefore, it should be deleted.

LCGME/CCME Recommendation #5

A national health insurance system should provide support for research and development of programs in graduate medical education.

Review Committee Recommendation

This recommendation should be deleted since it is included in the following recommendation.

LCGME/CCME Recommendation #6

A national health insurance system should provide support for modification of programs in graduate medical education through the appropriate expansion of existing programs, the addition of needed new programs, or the elimination of programs which no longer fit the aims of education or needs of patient care.

Review Committee Recommendation

A national health insurance system should provide support for modification of programs in clinical post-doctoral medical education through the appropriate expansion of existing programs, the development and addition of needed innovative programs, and should facilitate the elimination of programs which no longer fulfill the aims of education or needs of patient care.

LCGME/CCME Recommendation #7

Any system of national health insurance should provide for ambulatory patient care. The recommendations 1-6 shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of graduate medical education in the ambulatory setting, including facilities, space and equipment.

Review Committee Recommendation

Any system of national health insurance should provide for and encourage clinical post-doctoral education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of clinical post-doctoral education in the ambulatory setting, including facilities, space and equipment as well as personnel.

ATTACHMENT III

PROPOSED MODIFIED CCME/LCGME RECOMMENDATIONS
REGARDING NATIONAL HEALTH INSURANCE

Recommendations

(1) For purposes of reimbursement under national health insurance, the costs of approved programs of clinical post-doctoral education in teaching institutions shall be included as an allowable cost (a cost of doing business). The allowable costs of graduate medical education include, but are not limited to, the recompense of clinical post-doctoral trainees (interns, residents and fellows), payments to supervisors and teachers, and are applicable to both inpatient and outpatient services as well as the cost of space, equipment and supplies. Revenue from grants, endowments and other available sources ~~applicable~~ *(restricted)* to clinical post-doctoral medical education *(by the donor)* should be deducted from total cost prior to determining reimbursement cost. The manner and amount of compensation for clinical post-doctoral trainees should be left to local option.

(2) Any system of national health insurance should provide for and encourage clinical post-doctoral education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of clinical post-doctoral education in the ambulatory setting, including facilities, space and equipment as well as personnel.

(3) The recognition of the costs of approved programs in clinical post-doctoral education as an allowable cost shall be acknowledged and paid by all purchasers of health care services whether governmental or private.

(4) A national health insurance system should provide support for modification of programs in clinical post-doctoral medical education through the appropriate expansion of existing programs, the development and addition of needed innovative programs, and should facilitate the elimination of programs which no longer fulfill the aims of education or needs of patient care.

( ) - *Added by COTH Administrative Board June, 1975*

ATTACHMENT IV

SUMMARY

AAMC National Health Insurance Task Force Report

I. Scope of Coverage: any NHI system needs to be based upon mandated, universal coverage.

II. Benefit Structure: a uniform comprehensive package of benefits, covering all medically necessary physician and hospital services with limited deductibles and coinsurance payments. Exclusions from coverage should be well defined and well reasoned.

III. Cost-Sharing: if required, deductibles, coinsurance, and/or co-payments should be at a reasonable level which avoids over-utilization yet is not burdensome upon the population. Providers should neither be responsible for collecting cost-sharing payments nor for determining eligibility.

IV. Financing: the divided opinion of task force members prohibited the development of a firm policy statement.

V. Regulation of the Insurance Underwriter: a single, federal agency, independent of the NHI administration. Duties should include promulgation of standards for carrier solvency, risk-selection, loss ratios, and premium rates.

VI. Provider Regulation: the regulation of provider reimbursement and health care costs should be located at the state or substate level under federal guidelines; should include effective mechanisms for due process and appeals.

VII. Provider Reimbursement Standards: the system should provide a fair and reasonable reimbursement policy which meets the institution's full financial needs, including capital replacement, asset depreciation, amortization of debt and adequate operating margin. There should be valid, differentials among types of providers and recognition of the cost of federally imposed regulatory measures. The policy should not impede the training and education of graduate and undergraduate medical students.

A. The policy should not, for example, in setting conditions under which fee-for-service reimbursement of teaching physicians is to be made, require the kind of financial test and other conditions imposed by section 227 of the Social Security Amendments of 1972.

B. There should be recognition and allowance for the fact that the cost of services delivered in the teaching hospital will be greater for at least three reasons:

(1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital;

(2) the comprehensiveness and/or intensiveness of services provided by the teaching hospital;

(3) the teaching hospital's commitment to the incremental costs of providing the environment for medical and paramedical education programs.

VIII. Resource Development and Distribution: NHI is an appropriate mechanism for financing graduate medical education as a means of replenishing health manpower and for assuring the construction of needed medical facilities and services. The system may also be used to influence the quality and types of physicians that are trained.

IX. Effect on Other Federal Programs: separate, existing federal programs, e.g., VA, public health service hospitals, Indian Health Service and Champus, should be integrated into and made to conform with the national health insurance system.

X. Role of Philanthropy: reimbursement formulas should provide that unrestricted endowment principal and income and charitable contributions not be included in determining hospital payment rates. NHI provisions should continue to encourage charitable contributions and allow their use without restrictions.

APPENDIX II

COD BOARD MINUTES

9/18/75

Association of American Medical Colleges

TASK FORCE ON IMPLEMENTATION OF HEALTH PLANNING LEGISLATION

(P.L. 93-641)

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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 25, 1975

Mr. Eugene Rubel
Director
Bureau of Health Planning
and Resources Development
Department of Health, Education
and Welfare
3600 Fishers Lane
Room 1111
Rockville, Maryland 20852

Dear Mr. Rubel:

The Association of American Medical Colleges is pleased to submit the enclosed paper for consideration by the HEW Bureau of Health Planning and Resources Development. The paper represents the Association's interpretation of and comments on Section 1513(e) of P.L. 93-641, "Planning Agency Review of Proposed Uses of Federal Funds."

During previous meetings held between your staff and the staff of the AAMC, it was indicated that the Bureau was interested in receiving our assistance and input in resolving issues of critical importance. In an effort to provide the most effective response, the Association formed a special Task Force to formulate our position. This paper, therefore, will serve to furnish you with the Association's views regarding planning agency review responsibility and authority for programs designated for funding under titles IV (National Institutes of Health) and VII (Health Research and Teaching Facilities of Professional Health Personnel).

In summary, the Association recommends that:

- Program funds for undergraduate medical education under title VII should be exempt from Agency review. Certain title VII funds for graduate medical education that <u>have as their central purpose to impact on the local health resources may appropriately be subject to a voluntary consultative review</u>.

- Title IV research funds designated for the basic sciences and research projects with minimal service components should be exempt from Agency review.

- HEW may wish to encourage a voluntary consultative review between project recipients and Agencies for the limited number of Title IV research programs that have a significant "patient service component," e.g., large clinical projects, large cancer demonstration programs.

Please feel free to contact me should you wish to discuss these recommendations in greater detail.

Sincerely,

John A. D. Cooper

Enclosure

AGENCY REVIEW OF FEDERAL FUNDS UNDER TITLES IV AND VII

The purpose of this paper is to present the views of the Association of American Medical Colleges concerning the Health System Agency and Statewide Health Coordinating Council (SHCC) review of proposed uses of Federal funds under P.L. 93-641. It is authorized in the law that the Health Systems Agency is responsible for the review and approval or disapproval of certain proposed uses of Federal funds for health-related projects in their respective health service areas.

Section 1513(3)(1)(A) states that:

> ". . . each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds --
>
> "(i) appropriated under this (Public Health Service) Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 for grants, contracts, or loans, or loan guarantees for the development, expansion, or support of health resources; or
>
> "(ii) made available by the State in which the health service area is located from an allotment to the State under an Act referred to in clause (i) for grants or contracts for the development, expansion, or support of health resources."

In addition, there are specific exceptions from mandated HSA review and the following exemption is in Section 1513(e)(i)(B):

> "A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under Title IV (National Institutes of Health), VII (Health Research and Teaching Facilities of Professional Health Personnel), or VIII (Nurse Training) of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services."

It can be assumed that the law provides that, with the exceptions noted directly above, most projects funded through the Public Health Service Act, the Community Health Centers Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, will require review and approval by the HSA. Certain projects, however, should be designated a priori as being exempt from review. The discussion in this paper relates, for the most part, to the programs funded through Title IV and Title VII, and provides the Association's recommendations on planning agency responsibility for review of these two titles.

Title IV - National Institutes of Health

Projects funded under Title IV of the Public Health Service Act should be considered separate from Title VII with regard to the agency review authority. Clearly the intent of Congress, as stated in the Senate Report, was to exempt from HSA review research in the basic biomedical or health care delivery areas.

The Association believes that Title IV biomedical and behavioral research programs were intended to be exempt from the agency's scope of review. These research efforts are not undertaken to provide health services to the general population nor are the programs providing an additional resource which has as its central purpose the delivery of health care. Any curative patient care outcome which results will occur as a byproduct of the research activity rather than its immediate purpose.

The Association also belives that research funds designated for the basic sciences and research projects with a minimal patient service component should be exempt from Agency review. Characteristically, these projects are supported to address national questions of scientific importance and opportunity. It would not be in the best interests of the HSA which is not equipped to make knowledgeable scientific determinations, to be burdened with these reviews.

Some NIH research programs may impact on the health delivery and health resources in a surrounding area. Neither the program intent nor program objectives, however, are to change the health status of the local community. Activities such as the larger clinical trials, the comprehensive or specialized cancer and heart centers, and large control demonstration and health education programs are examples of these programs. The extent of the "patient service component" is these projects may serve as a motivation for local HSAs to pursue a voluntary consultative review. As an alternative to mandatory review of NIH programs, it is recommended that HEW encourage a voluntary consultative review between the and HSA as a means to achieve coordination.

The exemption for review of NIH research programs under Title IV should be extended to include research authorized under other titles of the Public Health Service Act and under other legislation. The intent of Congress is to have "research" exempt regardless of the source of support. Examples of these research programs include sickle cell disease and Cooley's anemia (Title XI).

Another NIH program which should be excluded from Agency review is the biomedical communication program. One of the purposes of the communications network is to provide "technical assistance." These efforts to facilitate the development of biomedical information and communications to be used as national resources are funded under Title III authority. Because the purpose of these projects is to test the feasibility of new communication techniques, and not to be used as a major part of the area health resources, the biomedical communications program would best be kept exempt from review.

If the voluntary consultative review process is adopted, there are other factors which should not be included in any such reviews. The Association believes that an agency should not be responsible for judging and evaluating

a project's scientific value, technical quality or the availability of safeguards for protection of human subjects. These factors are more properly and effectively determined by the NIH funding authority. Neither the staff capabilities nor agency resources will permit the agencies to review for these factors. More importantly, these matters are already the subject of an experienced and well developed review process and consequently, additional reviews by an HSA would be redundant as well as in all probability inexpert. Similarly, issues of confidentiality for research protocols must be assured throughout the entire review process.

Title VII - Health Manpower Training

The Senate Report (No. 93-1285) on the planning legislation makes it clear that "Federal funds intended to support research, or the training of health professionals are exempt from the review requirements of the proposed legislation." The Report of the Senate Committee on Labor and Public Welfare further notes that "research in the basic biomedical or health care delivery areas, and the training of health care personnel have an impact beyond the geographic boundaries of a particular area, and, therefore, are not an appropriate subject for review by the local health planning agency."

Legislation for the Title VII manpower provisions expired last year and to date, Congress has not enacted new legislation. Therefore, comments on HSA review of applications for funding submitted under Title VII must be considered in light of this situation.

The Association believes that manpower capitation funds should be totally exempt from state and local agency review. Since the purpose of these grants is for the development of national manpower resources, it is not an appropriate item for a local Agency to review. Also recommended as exempt from review are student loans, student assistance and financial distress grants. These educational programs are not for the support of final professional training points but rather mid-points in the continuum of medical education. Therefore, it is recommended that Title VII funds which are designated for undergraduate medical education be exempt from review.

There are certain special project grants for graduate medical education such as primary care programs and family medicine training, traineeships and fellowships which have an identifiable goal to achieve within the local area and may have as their primary purpose to impact on the local health resources and affect the availability of area health services. Although there is a relationship between residency training and the physician manpower needs of an area, the substantial amount of migration renders any projections less than meaningful. It is therefore recommended that HEW refrain from mandating HSA review of these graduate medical education funds, recognizing that if these programs have as their central purpose to impact on the local health resources, they are more appropriately subject to HSA voluntary consultative review.

General Comments

The sequence of project submission and review as it applies to the Health Systems Agency and the Federal Program funding authority is of particular importance to the review process. Unless exempt, an applicant will need the approval of both the HSA and the Federal agency prior to a final award of grants of contracts. Prior to HSA approval, an applicant should secure Federal agency approval in a manner similar to the current procedures; the applicant would then be required to seek HSA approval. Each review, however, should be separate and distinct, based upon predetermined criterion.

It would be advisable to foster early involvement of the local Agency and the project recipient. To minimize an Agency's work load, however, it is suggested that the HSA not make a final determination until it receives the finding of the Federal funding agency. This would also serve to prevent an HSA from "approving" projects which have not received the funding authority's review for technical quality, scientific relevance and program conformity. One last final caveat should be noted. The competitiveness of the environment demands that all reviews be timely and that special consideration be given to an appeals process that does not hinder or inhibit an applicant from receiving a project award.

"Renewal" and "continuation" of a project made in the absence of a Federal funding agency review should similarly be exempt from HSA review. A significant change in a project's work scope and/or an on-going project which receives a full review by the Federal funding agency should be appropriately reviewed by the HSA. Any project which was previously held to be exempt from HSA review and approval, should continue as such unless there is a determination by the Federal funding agency that the scope or purpose of the study has been altered so as to place it in a project category subject to review.

The Association believes that the intent of Congress was to utilize an HSA to coordinate other Federal health programs. Therefore, to the extent that it is "administratively feasible" the HSA should use its authority to monitor and review Federal health activities in their health service area from Agencies other than that of DHEW. It is further recommended by the Association that the Veterans Administration be urged to participate in the planning and review approval process in those areas where a V.A. health facility exists.

Comments on LCME "Draft Proposed Guidelines for Peripheral Clinical Components"

By the attached letter, Dr. VanCitters suggests that the action of the LCME to address Deans individually soliciting comments on the "Proposed Guidelines" is unfortunate and inappropriate, it being his view that it calls for a more formal review by the AAMC.

It is the understanding of the staff that this document is a "working draft" prepared by a subcommittee of the LCME, received and considered by the LCME but not adopted by it pending the receipt and consideration of comments from the Deans. This solicitation of comments at an early stage of the document's development was intended to place the LCME in compliance with the "legislative due process" requirements of the Office of Education. Basically, this requires that parties which will be primarily affected by the promulgation of new procedures have the opportunity to comment on them at a sufficiently early stage as will permit their views full consideration in the deliberative process, i.e. before the document is effectively in final form.

We anticipate that the LCME will take cognizance of the comments received, revise it as appropriate and formally adopt the document subject to ratification by the AAMC Executive Council and the AMA Council on Medical Education. Thus, the AAMC will have an opportunity to formally review the document at a later date.

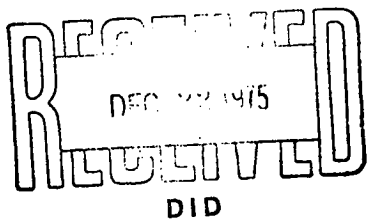
RECOMMENDATION:

That the COD Administrative Board consider the document at this time and forward such comments as it may have for revision of the draft document; that it express its expectations to the LCME with respect to the opportunity for a more formal review of the adopted draft by the AAMC.

UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON 98195

16 December 1975

School of Medicine
Office of the Dean



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

Dear Marjorie,

I recently received a copy of a general mailing to all Deans from Richard Egan of the LCME on the subject of proposed guidelines for peripheral clinical components. In brief, the LCME was sampling the reaction to a draft copy of a set of guidelines which would be incorporated into the Functions and Structure of a Medical School out of recognition for the increased number of peripheral clinical components now coming into use.

Although the cover letter asked for comments, I wonder whether this is not something that should be subject to more formal review by AAMC. I think it is unfortunate, and even inappropriate, that LCME has chosen to address the Deans individually on this matter; I would have thought that they might have asked for a statement from AAMC itself, and that AAMC would have had an opportunity to formulate an overall response.

Sincerely,

Robert L. Van Citters, M.D.
Dean

RVC:slp

LIAISON COMMITTEE ON MEDICAL EDUCATION

Council on Medical Education
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

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

M E M O R A N D U M

TO: Deans of Approved Medical Schools

FROM: Richard L. Egan, MD, Secretary RLE

DATE: November 26, 1975

SUBJECT: Proposed Guidelines for Peripheral Clinical Components

During the past two years, the Liaison Committee has at several meetings reviewed the application of the standard for accreditation, Functions and Structure of a Medical School, in relation to the increasing number of peripheral clinical components utilized for the education of medical students.

As a result of these reviews a Task Force of the Liaison Committee has prepared a draft of guidelines to assist in the evaluation of peripheral clinical components.

At its last meeting the Liaison Committee considered the draft copy which is enclosed. Further consideration was deferred until comments could be solicited from interested and knowledgeable medical educators.

Therefore your comments are requested and will be gratefully received. An envelope for your comments is enclosed. Since the next meeting of the Liaison Committee is scheduled for January 21, 1976, an early reply will be helpful.

RLE/gg

This draft copy is not a statement of policy of the Liaison Committee on Medical Education and is for discussion only.

GUIDELINES FOR PERIPHERAL CLINICAL COMPONENTS

Responding to felt public needs, more and more medical schools are conducting clinical training at geographically separate sites involving affiliated community-based hospitals and mainly volunteer faculty.

Experience has indicated that existing accrediting guides provide for satisfactory evaluation of the educational contributions of elective courses as well as the occasional required clerkship in a remote specialized facility.

Recently programs have been instituted or proposed which would require medical students to spend a large share of their required clerkship time beyond reasonable commuting distance from the academic medical center. Under these circumstances, additional guidelines to the "Functions and Structure of a Medical School" are necessary to assure quality control of the educational program to maintain a critical number and variety of qualified faculty and to promote high quality education for medical students.

The Liaison Committee on Medical Education will evaluate such academic units of an accredited school of medicine when they can clearly qualify as an integral component of the parent school. The LCME does not consider for accreditation free-standing clinical schools.

GENERAL REQUIREMENTS

In order for an accredited medical school to develop an acceptable peripheral clinical component it must be prepared to station properly qualified faculty and offer a significant portion of its major required clinical clerkships at this site.

This draft copy is not a statement of policy of the Liaison Committee on Medical Education and is for discussion only.

Since the accreditation of the parent school is dependent upon the quality of all of its programs, responsibility and authority for the conduct of the branch program must be vested in the parent school.

The school must provide for a critical mass of students, faculty and resources and give evidence of community support for the program.

EDUCATIONAL PROGRAM

The clinical program must be articulated with both the Basic Science and the Graduate Medical Education programs. The clinical experience should be sufficiently broad to include instruction in basic mechanisms of disease in all major clinical specialties. It is desirable to have an approved residency program in each discipline offering clerkships so that both the supervising faculty and housestaff can serve as role models and teachers.

Although the program is geographically distant the curriculum must be planned, administered and evaluated in concert with the appropriate faculty committees, departmental chairmen and other administrative officers of the parent school.

ADMINISTRATION AND GOVERNANCE

All acceptable undergraduate medical education programs in the clinical sciences must be conducted by a medical school accredited by the LCME. The principal academic officer of the component program should be appointed to or be a member of the faculty of the parent school with full privileges and be administratively responsible to the chief executive officer of the degree-granting medical school.

There should be a precise definition of the relationships of the members of the faculty and administration of the branch as a part of the parent medical school.

Educational facility planning, teaching budget and allocation of other educational resources, academic program planning, faculty appointment and student assignments should be coordinated and integrated with the parent campus.

If the clinical program of the branch is conducted in clinical facilities other than one owned by the medical school or its parent university, appropriate affiliation documents must vest the authority for the conduct and evaluation of the educational program in the degree-granting medical school.

FACULTY

Experience has shown that in the branch as well as on the parent campus there must be a core of full-time faculty in addition to part-time and volunteer faculty. The numbers, types and specialties of faculty at the branch will be determined by the degree-granting medical school. The academic plan must assure that the remotely based members of the faculty meet the same standards and enjoy the same responsibilities, status and privileges in regard to appointment, tenure, pay, fringe benefits, committee memberships, student selection, curriculum development as those members of the faculty on the parent campus.

Encouragement of all faculty in the pursuit of creative scholarly activity, including provision of time and facilities for research, is essential. There should be a single process for faculty appointments and promotions for the parent medical school and its components.

STUDENTS

The degree-granting school should be responsible for selection, assignment, promotion and evaluation of all medical students. Within

reasonable limits the student should be able to move freely between the branch and the parent campus.

Medical students transferring from another school should spend a minimum of eight months on the main campus before being eligible to rotate to a branch. Students assigned to a branch should receive the same privileges and access to student services as students on the main campus.

FINANCES

In most circumstances the principal academic officer of the clinical branch will prepare an annual budget for review and approval by the chief executive officer of the parent school. It is anticipated that sponsored support such as research grants will be used to achieve financial balance at the clinical branch in a similar manner to the parent campus. The parent institution must assure adequate additional financial resources to operate the branch.

FACILITIES

Facilities will vary with the size and the type of program; the quantitative requirements will be determined by the number of students and the extent of the curriculum offered at the clinical branch. It is important that the clinical program include experience in ambulatory care in addition to inpatient training.

In addition to appropriate clinical facilities, the branch campus must provide adequate library services, administrative space, faculty offices and laboratories and teaching space including provisions for conference rooms, lounges, study areas and laboratories.

This draft copy is not a statement of policy of the Liaison Committee on Medical Education and is for discussion only.

ACCREDITATION

A school of medicine proposing the development of a new clinical branch must inform the Secretary, LCME, in time to allow for consultation, site inspection and appropriate review of both the parent school and the branch before medical students may be assigned.

Periodic reaccreditation surveys will normally include the parent school as well as the branch campus.

These guidelines are intended to be used as a supplement to the Liaison Committee's document, "Functions and Structure of a Medical School," which embodies the basic policies approved by the Liaison Committee on Medical Education, the Association of American Medical Colleges and the American Medical Association by which medical schools are accredited. Thus, the guidelines are not intended to be all inclusive or comprehensive. Subjects which are not addressed specifically are presumed to fall within purview of other documents relating to the accreditation of the medical school.

This draft copy is not a statement of policy of the Liaison Committee on Medical Education and is for discussion only.

Appendix

Guidelines for Peripheral Clinical Components
Definition of Terms

1. School or College of Medicine - An institution of higher learning chartered and accredited to offer the full course of undergraduate medical education culminating in the award of the M.D. degree.

2. Dean - The chief executive and principal academic administrative officer of a school of medicine.

3. Principal academic officer of a branch - The local representative of the Dean and on-site administrator of the component program.

4. Components of a school of medicine - In recent years some of these activities of accredited schools of medicine have been aggregated as basic science, clinical science or mixed components organized as distinct administrative or instructional units housed in locations geographically distant from the main campus of the school of medicine. By definition such educational units offer only a portion of the curriculum required for the M.D. degree. A clinical component may be located in an affiliated hospital but affiliated hospitals per se do not constitute a clinical component as here defined.

FINANCIAL ASSISTANCE FOR MEDICAL STUDENTS

The continuing concerns of the AAMC about financial aid for medical students and the inadequacies of federal support were heightened by the responses of the medical schools to a survey conducted at the request of the Congressional Budget Office (Attachment I). Apart from the dollar increments in tuition, the number of school officers who perceive that there is a change in the applicant pool (Q#11) is impressive. The schools have been queried about whether or not documentation on this point is available.

Existing AAMC data (Attachment II) show that already in 1974 a decreased fraction of entering students were drawn from families with incomes under $15,000 as compared to final year students. There is a corresponding increase in the fraction whose family incomes exceeded $20,000. This is supported by the applicant data from the last 3 years, although inflation is also a factor in these changes.

The third attachment was prepared by Robert Boerner, Division of Student Programs. It summarizes the status of current resources for student assistance, legislative developments and the efforts of the AAMC.

ATTACHMENT I

November 20, 1975

Bonnie Lefkowitz
House Office Building
Annex #2
Second and D Street SW
Washington, D.C. 20515

Dear Ms. Lefkowitz:

At your request the AAMC conducted a survey of medical schools in the U.S.A. asking for their estimates of tuition for the next three years with three levels (1500, $750, and none) of federal capitation support. Thirty three of forty-five private schools responded (73.3%); 52 of 69 public schools responded (75.4%), although less than half of the latter were able to give forward projections, probably because they often do not control the tuition rate. Twenty-five of the private schools indicated that they currently received additional support from state governments.

In Table 1 are given the Ranges, Medians and Means of the tuition projections for the next three years at the three capitation levels.

In Table 2 are given the mean estimates of tuition for the public schools. These numbers should be used with marked caution since the number of responses is low, and many of the state schools neither control the tuition nor receive it directly. It seems fair to conclude that the rate of change for the responding public schools appears to be as great as that for the private schools.

I call your attention to the third attached page which summarizes the responses to questions about tuition dollars and the budget of schools and about the effects of student financial problems.

If there is further information I can give you, please feel free to call me.

Sincerely,

George R. DeMuth, M.D.
Deputy Director
Department of Institutional Development

Private Medical Schools[1]

School Year	ESTIMATED TUITION Range	Median	Average	Number of Schools Reporting
1975-76	$1,850 - $4,900	$3,750	$3,660	33
1976-77				
$1,500 capitation	2,100 - 6,450	4,375	4,230	32
$750 capitation	2,500 - 7,200	5,000	4,860	31
No capitation	3,000 - 7,950	5,500	5,510	31
1977-78				
$1,500 capitation	2,300 - 7,000	4,800	4,610	31
$750 capitation	2,700 - 7,750	5,500	5,220	30
No capitation	3,200 - 8,500	6,000	5,920	30
1978-79				
$1,500 capitation	2,500 - 7,500	5,300	4,970	31
$750 capitation	2,900 - 8,250	5,750	5,590	30
No capitation	3,400 - 9,000	6,500	6,300	30

[1]Four private medical schools reported lower tuition for residents than for non-residents; the higher tuitions for these schools are used in the table.

Public Medical Schools

School Year	ESTIMATED TUITION Range	Median	Average	Number of Schools Reporting
1975-76				
Resident			$1,195	52
Nonresident			2,400	52
1976-77				
$1,500 capitation				
Resident			1,620	24
Nonresident			3,330	24
$750 capitation				
Resident			1,990	22
Nonresident			3,650	22
No capitation				
Resident			2,340	21
Nonresident			4,050	21
1977-78				
$1,500 capitation				
Resident			1,840	21
Nonresident			3,840	21
$750 capitation				
Resident			2,350	19
Nonresident			4,360	19
No capitation				
Resident			2,850	18
Nonresident			5,040	18
1978-79				
$1,500 capitation				
Resident			2,010	21
Nonresident			4,170	21
$750 capitation				
Resident			2,550	19
Nonresident			4,730	19
No capitation				
Resident			3,100	18
Nonresident			5,420	18

	Responses YES	NO
Question 7		
If you are a private medical school, do you receive support for undergraduate medical education from your state?		
Private schools	25	7
Question 8		
Are increments in medical school tuition directly reflected in your school budget?		
Private schools	30	2
Public schools	16	35
Question 9		
In the last year, have any medical students dropped from registration primarily because of personal financial problems?		
Private schools	3	30
Public schools	2	50
Question 10		
Do you expect any medical students this year to drop from registration primarily because of personal financial problems?		
Private schools	7	25
Public schools	4	47
Question 11		
Do you have any evidence that financial problems have affected your applicant pool?		
Private schools	14	19
Public schools	12	39

ATTACHMENT II

Table 8

Distribution of Medical Students by Gross Parental Income and Medical School Class

Family Income	All Classes	Medical School Class		
		First Year	Intermediate	Final Year
Total[1]	100%	100%	100%	100%
Less than $5000	6	5	6	6
$5000 - $9999	11 (35)	10 (31%)	11 (35%)	10 (36%)
$10,000 - $14,999	18	16	18	20
$15,000 - $19,999	15	15	15	15
$20,000 - $24,999	13	14	13	12
$25,000 - $49,999	24 (50)	26 (54%)	24 (50%)	23 (49%)
$50,000 or more	13	14	13	14
Estimated Median	$20,249	$21,333	$19,880	$19,553

[1] Based on students who supplied data on family income in April 1975 AAMC Survey of "How Medical Students Finance Their Education".

Prepared by Davis G. Johnson, Ph.D., 12/5/75. (Medians added on 12/30/75).

APPLICANT STUDY DATA

Applicants by Parental Income	1973-74 N	- %	1974-75 N	- %
Less than $5,000	2,685	8.7	2,757	6.9
$5,000 - $9,999	5,650	18.3	5,059	12.7
$10,000 - 11,999	7,483	24.2	4,958	12.4
$12,000 - 14,999	4,886	15.8	5,853	14.6
$15,000 - 50,000+	10,155	32.9	21,330	53.4
No Response	9,647		2,667	
	40,506		42,624	

Note: 1. Figures not corrected for inflation.

2. Markedly different response rates for 1973-74 and 1974-75 may distort figures somewhat.

STATUS REPORT ON MEDICAL STUDENT ASSISTANCE

To illustrate the severity of the crises in student assistance, in the 1974-75 academic year the total amount of financial aid needed by medical students as determined by the 109 medical schools which reported on the Liaison Committee on Medical Education Annual Questionnaire was $92.8 million. That same survey showed only $52.8 million from all sources disbursed by the schools to the 24,192 students (46.8% of the total enrollment) who evidenced financial need. Despite the fact that the additional funds from major sources not administered by the schools totaled an additional $37.7 million raising available funds to $90.5 million the situation in 1974-75 was critical.

In 1975-76 it has become worse. The Health Professions Scholarship Program which supplied $6.3 million to medical schools in fiscal year 1974 was reduced to $2.8 million in fiscal year 1975, and this year has been eliminated entirely. The $15.1 million available to medical schools through the Health Professions Loan Program in fiscal year 1975 has been reduced to approximately $10 million this year with first-year students no longer eligible for these finds. In addition, financial aid officers across the country are reporting that it is exceedingly difficult this year for medical students to receive funds from banks through the Federally Insured Guaranteed Student Loan Program which in 1974-75 supplied $28.3 million to medical students.

The other two major Federal programs, the Public Health Service/National Health Service Corps Scholarship Program and the Armed Forces Health Professions Scholarship Program are not in a strict sense financial aid programs since each requires a service commitment and neither uses financial need as a primary selection criteria. Students who actually need funds to complete their medical education, therefore, may not be selected to either program. The funds from the Public Health Service program for a given year have thus far not been available to students until the academic year is at least half completed which further reduces their usefulness as a source of support.

In the private sector, National Medical Fellowships which provides scholarships to first and second year minority medical students based on support which is solicited from various private foundations has reduced its awards from $2.3 million in 1974-75 to $1.8 million in 1975-76. In 1972-73 the Robert Wood Johnson Foundation made available $10 million in financial assistance to the medical and osteopathic schools to be used over a four year period either as loans or scholarships for minority, female and rural students. These funds which have been apportioned by the schools at approximately $2.5 million per year since 1972-73 will

terminate at the close of the current academic year. The majority of this money has been made available as scholarships and thus will not be repaid in the future to be again used as financial assistance to students. The American Medical Association Education and Research Foundation which is the other major source of assistance to medical students from the private sector made available $4.6 million in 1974-75. Their forecast for 1975-76 is that approximately $5.0 million will be loaned.

Thus it appears that the financial need of students in 1974-75 exceeded existing major funds from both the private and public areas by approximately $2.3 million. Although complete data is not yet available, we know that there have been the above reported decreases in the amount of financial assistance available in 1975-76 approximating $8.0 million. At the same time due to the uncertainty of Federal funding and many other factors medical school tuition since 1974-75 has and will continue to rise significantly as will living expenses due to inflation. Therefore the financial need of medical students has increased over the past year while the amounts available in the form of financial assistance from all sources had decreased. The present disparity between necessary and existing major sources of financial aid to medical students certainly exceeds $10.3 million and may be as much as $15 to $20 million.

The most recent Association attempts to deal with these problems began on November 5 when members of the Group on Student Affairs (GSA) Committee on Financial Problems of Medical Students and AAMC staff met with several HEW policy analysts to discuss the current problems of financial assistance to students in the face of rising tuition, the drop in available health professions loans, the phaseout of the health professions scholarships, the hesitation on the part of banks to make guaranteed or private loans, the impending termination of Robert Wood Johnson funds for women, minority and rural students, and the decrease in foundation support for National Medical Fellowships and for student assistance in general. The committee members evidenced concern about the Administration proposal for a grant program for minority students for two years of premedical education and for the first year of medical school and suggested that grants for minorities include at least the first two years of medical school. The committee members proposed an extension of the Health Professions Loan Program for three years at the $50 million level. With BHM clearance the AAMC made available data from the recent survey on "How Medical Students Finance Their Education" to the analysts on the HEW staff to aid their planning. Following this meeting HEW has indicated its recommendation for a phaseout of the Health Professions Loan Program adding that an income-related loan program is being considered.

On November 18, 1975, AAMC testimony presented before the Subcommittee on Health of the Senate Labor and Public Welfare Committee ranked the need for student assistance a high priority for consideration. It stressed the need for "continuation and expansion of the Health Professions Loans" at the level of $50 million annually to prevent economic exclusion from medical school in the face of increasing education expenses and the increased cost of living.

Another area of Association activity has addressed the ineligibility of first year students for Health Professions Loan funds which resulted on June 30, 1975 from the expiration of the fiscal 1975 resolution continuing the provisions of this loan program as part of the Health Manpower Education Act of 1971. To alleviate this situation an amendment supported by the Association which would renew the eligibility of first year students for these loan funds was added to the Senate version of the current Heart-Lung Bill. The Senate has passed this bill and the amendment and the bill is presently in conference. The House passed an earlier version which did not include the amendment. Indications are that the House members of the Conference Committee will support the amendment, but there is no clear timetable for emergence of the bill from the committee or signature or veto by the President.

Another recent development has been an inquiry from the Kellogg Foundation about the status of financial assistance to medical students. In response to that inquiry the Association provided data which may generate further interest in the problem and possibly some type of financial assistance for medical students on the part of the Foundation.

Division of Student Programs
January 1976