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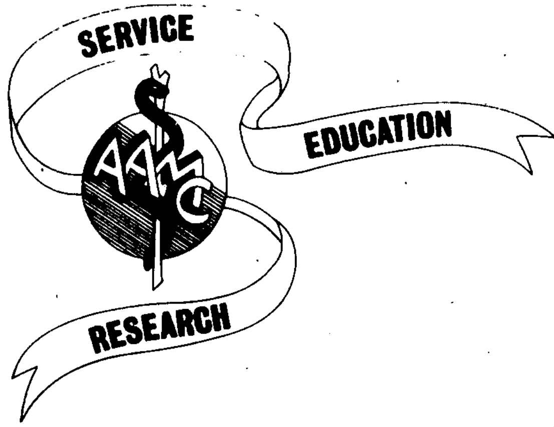

AGENDA
FOR
COUNCIL OF DEANS

ADMINISTRATIVE BOARD

THURSDAY, MARCH 25, 1976

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle, N. W.

Washington, D. C.

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FUTURE MEETING DATES

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

AAMC Annual Meeting ----------------------- November 11-15, 1976
San Francisco Hilton

COUNCIL OF DEANS
ADMINISTRATIVE BOARD
March 25, 1976
9 a.m. - 1 p.m.
Washington Hilton Hotel
Kalorama Room

AGENDA

Page

I. Call to Order

II. Chairman's Report

III. Action Items

A. Approval of Minutes ---------------------------------- 1

B. Executive Council Actions--

1. LCME Membership in the Council on Postsecondary Accreditation (Executive Council Agenda)..(20)

2. LCME Guidelines for Functions and Structure of a Medical School (Executive Council Agenda)....................................(21)

3. Criteria for Subscribers (Executive Council Agenda)....................................(52)

4. Approval of Subscribers (Executive Council Agenda)....................................(54)

5. Admission of Women to Medical School (Executive Council Agenda)...........................(57)

6. Report of the Task Force on Continuing Medical Education (Executive Council Agenda)......(59)

7. Governmental Cognizance of the Institutional Well-being of Academic Medical Centers (Executive Council Agenda)................(65)

8. OSR Accreditation Pamphlet (Executive Council Agenda)....................................(87)

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IV. Discussion Items

A. Report of OSR Administrative Board Actions

B. DHEW Forward Plan for Health--AAMC Comments (Executive Council Agenda)..................(67)

C. Correspondence with The Wyatt Company on Malpractice Exposure of Faculty Physicians (Executive Council Agenda)..................(94)

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DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

January 14, 1976
9 a.m. - 1 p.m.
Edison Room
Washington Hilton Hotel

PRESENT

(Board Members)

J. Robert Buchanan, M.D.
Neal L. Gault, M.D.
John A. Gronvall, M.D.
Julius R. Krevans, M.D.
William H. Luginbuhl, M.D.
Clayton Rich, M.D.
Robert L. Van Citters, M.D.

(Guests)

Ivan L. Bennett, Jr., M.D.
Thomas Rado
Richard Seigel

(Staff)

Robert J. Boerner
John A. D. Cooper, M.D.
George R. DeMuth, M.D.
H. Paul Jolly, Ph.D.
Joseph A. Keyes
Diane Mathews
Jaimee S. Parks
James R. Schofield, M.D.
Bart Waldman
Marjorie P. Wilson, M.D.

ABSENT

Christopher C. Fordham, III, M.D.
Andrew D. Hunt, M.D.
Chandler A. Stetson, M.D.

I. Call to Order

The meeting was called to order at 9:00 a.m. by Dr. John A. Gronvall, M.D., Chairman.

II. Chairman's Report

Dr. Gronvall informed the Board of his attendance at the OSR Board meeting the previous day and reaffirmed his statement that the COD Administrative Board would devote substantial effort in cooperation with the OSR Administrative Board to develop more effective ways of working together on matters of mutual interest.

The Chairman then gave an overview of the AAMC Officers' Retreat, highlighting a "brainstorming session" devoted to identifying areas in which the Association ought to become more involved.

One area considered at the suggestion of Dr. Gronvall was indicated in the report of the retreat as "Factors Influencing Health Manpower Needs". The central idea was that rather than appointing task forces or committees to conduct research at the times when the Association finds itself concerned with particular legislative proposals, the Association might develop an on-going, longer term activity to better identify or clarify the kinds of system factors at work in the country which influence Health Manpower demands. By understanding these factors and their influence, the Association would be better prepared to deal with legislative proposals as they arise.

On the same topic, Dr. Gronvall told of a discussion with Drs. Bennett, Wilson and Ed Roberts, a consultant for the MAP Program, about the possibility of developing a Health Manpower model and systems dynamics. There will be further discussion at a future MAP seminar.

Members of the Board questioned whether the AAMC was the proper sponsor for such a project because the results would be subject to challenge on the basis of AAMC self interest. Dr. Gronvall responded that he viewed the project as designed for internal use to help us predict where pressures might arise, to identify specific areas requiring analysis and to assist in the development of more sophisticated strategies in dealing with societal needs and legislative pressures.

Concerns were raised about the usefulness of still another study on this topic at a time when others such as IOM, Rand and HEW are engaged in manpower projections, none of which is viewed as definitive. It was suggested that the Association should do something about identifying an institution that would be assigned the national responsibility for developing the definitive assessment of needs and numbers as the basis for coordinated policy making. In the absence of an acceptable uniform and agreed upon set of numbers, rational policy deliberation is excrutiatingly difficult if not impossible.

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The discussion then entered another area where numbers are significant: the trend of specialty boards to require first year post-doctoral training in general medicine and the narrowing gap between the number of U.S. graduates and the total number of first year positions available. These appear to be indicators that there may be a crisis in the making which the deans should be aware of and plan now to alleviate.

The next item in the Chairman's Report was a report on the 1976 Spring Meeting Planning Committee consisting of Drs. Fordham and Van Citters along with Dr. Gronvall. The basic format has been developed and the next meeting will focus on speakers and titles of presentations.

III. Minutes of Previous Meeting

The minutes of the September 19, 1975 meeting were approved as circulated.

IV. Executive Council Actions

A. CCME Report: Physician Manpower and Distribution: The Role of the Foreign Medical Graduate

At its September meeting, the Executive Council reviewed and approved the CCME Report on the Role of the Foreign Medical Graduate, specifically deleting three sections in accordance with its line-item veto power. At the most recent meeting of the CCME it was noted that all other parent organizations had approved the FMG Report in its entirety and the CCME requested that the AAMC reconsider its actions in deleting the three contested sections.

The provisions which were deleted by the Executive Council in September are listed below along with proposed alternate wording. In the first two instances this alternate wording was proposed by the CCME and would be acceptable as an editorial change. The third section dealing with Fifth Pathway programs is supported in its original form by the other members of the CCME; although this section did not appear in the original committee report to the CCME, it was added over the objections of several committee members after the CCME sponsored invitational conference.

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ITEM A-4

PROVISION DELETED BY AAMC

That commencing one year following the adoption of this report the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools or other accredited schools of the health professions;

ALTERNATE WORDING (PROPOSED BY CCME)

That commencing one year following the adoption of this report the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools together with affiliated hospitals or other accredited schools of the health professions.

The COD Administrative Board approved of the alternate wording of the item.

ITEM B-11

PROVISION DELETED BY AAMC

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 education deficits that handicap FMG's in achieving their full potential as physicians in the U.S. health care system; and

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ALTERNATE WORDING (PROPOSED BY CCME)

That on an intermim 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 agencies; 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 education deficits that handicap FMG's in achieving their full potential as physicians in the U.S. health care system; and

The alternate wording did not address the concerns raised by the provision's inclusion satisfactorily. This provision was opposed by the Board, because if CCME policy, it would be used as a lever of coercion on the institutions to establish such special programs. The Board voted to recommend the deletion of the provision.

ITEM C-6

PROVISION DELETED BY AAMC

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.

ALTERNATE WORDING (FROM AAMC POLICY)

That the special programs currently offered by some medical schools commonly called The Fifth Pathway Program should be phased out. Qualified U.S. citizens who have studied medicine abroad should be provided the same educational opportunities and recognition as their colleagues who enter U.S. medical schools directly. If resources can be made available, qualified students should be selected by the faculty and admitted to advanced standing. Their levels of admission should be determined by the policies of the faculty, and they should be provided the regular educational opportunity and challenge deemed necessary for the awarding of the M.D. degree.

The AMA is the only parent organization with a stake in the Fifth Pathway and therefore the only one wishing a statement of support for this program to be included. The alternate wording will probably be unacceptable to it. In the case of an AMA veto on the alternate wording and an AAMC veto on the original provision, both would be stricken from the report.

The OSR Vice-Chairperson, Thomas Rado, reported on the research of an OSR staff person, suggesting that Fifth Pathway had intrinsic weaknesses (i.e., the difficulty in obtaining the M.D. degree; ethical considerations involved). The recommendation of the OSR was not to approve or encourage the Fifth Pathway.

The Board recommended that the Executive Council press for inclusion of the alternate wording and seek to hasten the demise of the Fifth Pathway program.

Action:

The Board recommended that the Executive Council take the following actions in regard to the CCME Report:

Item A-4--approve alternate wording

Item B-11--recommend the deletion of the provision

Item C-6--press for inclusion of the alternate wording

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B. Association Membership in the Federation of Associations of Schools of the Health Professions

The Federation of Associations of Schools of the Health Professions was organized in 1968, principally by Dr. George Wolf. The formation of the Federation represented an effort to implement a Coggeshall Report recommendation which had expressed the need for more organized discussion and cooperation among educators in the various health professions. The following eleven organizations are members of the Federation:

American Association of Colleges of Pharmacy
American Association of Colleges of Podiatric Medicine
American Association of Dental Schools
American Association of Osteopathic Colleges
Association of American Medical Colleges
Association of American Veterinary Medical Colleges
Association of Schools and Colleges of Optometry
Association of Schools of Allied Health Professions
Association of Schools of Public Health
Association of University Programs in Health Administration
National League for Nursing

The Federation was originally conceived to provide a forum for discussion of common issues such as accreditation, licensure, the development of health care teams and the organization of health services. In recent years the focus of the Federation has been almost exclusively on federal legislation. Federation meetings are used as an audience for Congressional staff and on several occasions the Federation has been asked to testify on pending legislation in lieu of individual presentations by any of its members. The subject matter of Federation meetings is now so predominantly legislative that several associations send paid lobbyists or legislative counsel as their representatives.

In 1971 the Federation agreed to support pending health manpower legislation after extensive deliberation and debate. The Federation's ability at that time to speak with one voice probably aided the passage of the 1971 law. However, the Federation has been unable, in the past year, to find a common ground on the renewal of health manpower legislation. Although a uniform position was adopted in early 1974 after the expenditure of a great deal of time by several members of the AAMC staff,

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several members of the Federation proceeded to negotiate away the essence of this position in return for more favorable treatment of their particular interests. This individual lobbying eroded the Federation's common ground to the point where it can be said that there is no agreement whatsoever.

As a result of this shift in the Federation's interest away from the academic and toward the legislative, the American Association of Dental Schools has recently resigned from Federation membership.

The AAMC Executive Committee has previously reviewed membership in the Federation, which carries annual dues of $1,375. It was generally felt that the Association should continue to send a staff member to Federation meetings but should not participate in any joint legislative activities. It was generally felt that the Federation should be a colloquim for discussion but should not be involved in the development of legislative policy.

Action:

The Board recommended that the Executive Council authorize the President to communicate to the officers of the Federation a recommendation that it refocus its interest on substantive educational issues and agree to drop its focus on legislative issues, with the understanding that failure of the Federation to do so would result in an Executive Council action to withdraw the Association from membership.

V. Administrative Board Actions

A. Review of LCME "Draft Proposed Guidelines for Peripheral Clinical Components"

The LCME, in recognition of the increased number of peripheral clinical components being developed and the number of issues this raises with a regard to the accreditation of these schools drafted a set of guidelines for interpreting the provisions of "Functions and Structure of a Medical School." This draft document was sent with a cover memo to all deans with a request for comments or revisions.

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A letter was sent by one dean suggesting that the action of the LCME to address the deans individually may have been inappropriate and unfortunate, 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.

It is anticipated 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.

Members of the Board offerred numerous comments and suggestions for revision of the document. In general, their perception was that the definition of the entity under consideration needed clearer definition and that the tone of the document was far too directive and constricting. While they generally agree that the approach which the document reflected; namely, that such separate components should not be considered to have substantial autonomy but rather be integrated with the institution accredited by the Liaison Committee to award the M.D. degree, some of the specifications of the document directed toward achieving this integration were too specific and sometimes infeasible to implement in the institutional level.

Action:

The Board recommended that the document by revised significantly by the Liaison Committee.

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VI. **Discussion Items**

A. Control of Hospital Routine Service Costs

The Executive Council agenda included an outline of a legislative proposal expected to be introduced shortly by Senator Talmadge of the Senate Finance Committee. The proposal would substantially revise the basis upon which hospital routine service costs allowable for reimbursement under Medicaid would be determined. We have every reason to believe that it is in part at least a good faith effort to remedy by legislation the inequitable impact of Sec. 223 of P.L. 92-609 as interpreted by regulation. It would classify hospitals by a new procedure and separately calculate allowable costs associated with certain items which tended to distort the impact of previous classification schemes. Separately calculated would be a) capital costs, including interest and depreciation; b) costs of hospital education and training programs; c) costs of interns, residents and medical staff salaries; and d) energy costs. Malpractice insurance costs may also be included in the items separately considered.

While in many respects the proposal appears to be attractive, it is fraught with many potential difficulties: its feasibility depends on the development of a uniform accounting and cost allocation system; the method of determining allowable charges for the separately considered items has not yet been worked out; the approach focuses on the "cost of a day's care" rather than "per admission" costs or some other method which might be preferable; it continues a national centrally administered scheme with the inherent difficulties of such an approach.

Finally, the proposal identifies "the primary hospital of a medical center" (yet to be further defined) as a separate category for classification purposes. The definition of such hospitals presents both conceptual problems and potential political difficulty within the AAMC constituency. Additionally, the practical utility of such a separate classification may disappear after the items to be separately costed have been excluded from consideration of what constitutes routine costs.

The Board considered these issues but concluded that no specific recommended Association position should be developed by the Board. The Executive Council was

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determined to be the best forum for such deliberations because of the presence of the COTH members and the availability of the advice from that Council's Board.

B. 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. Apart from the dollar increments in tuition, the number of school officers who perceive that there is a change in the applicant pool (26 of 84 who responded to this question) is impressive. The schools have been queried about whether or not documentation on this point is available.

Existing AAMC data 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 exceeding $20,000. This is supported by the applicant data from the last 3 years, although inflation is also a factor in these changes.

The Board was presented with a summary of the status of current resources for student assistance, legislative developments and the efforts of the AAMC (Attachment A to these minutes).

In the discussion which ensued, the Board concluded that the data computed with the experience of its members and presented a distressing picture of a problem worthy of serious attention.

If tuition and the costs of medical education continue to rise and the resources for student assistance continue to fall, the nation faces the regrettable prospect that the opportunity for studying medicine and thus access to the medical profession will be increasingly limited to persons from families with substantial means. This retrogressive trend needs to be reversed.

Several strategies for dealing with this issue were discussed. It was suggested that the prospect for

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additional scholarship funds is very bleak. The political climate on the federal level appears to preclude the funding of any significant scholarship program. Assistance tied to service commitments will be available but in completely inadequate amounts to meet the real needs. Foundations face constricted resource availability and show little interest in medical student financial assistance as a problem deserving their support. Thus, it was suggested that the best approach would be to focus on the commercial banking industry, to stimulate recognition and a moral concern for the problem, and to work out mechanisms whereby acceptable long term loans might be made available in sufficient amounts. Here the Association's National Citizens Advisory Committee might provide the kind of expertise and professional liaison that might make such an effort pay off.

The Board determined to recommend that the Executive Council appoint an Association-wide Task Force to deal with this problem in detail, to study and report back, to develop and explore strategies and to provide a focus for a concerted Association effort to alleviate the problem.

C. OSR Administrative Board Discussions

Rich Seigel and Tom Rado, Chairperson and Vice Chairperson of the OSR respectively, were present for all of the preceding discussions and participated in them. The OSR Officers reported on the Board's discussions of the previous two days. The items included: curriculum and evaluation; medical student stress; women in medicine; the NIRMP and problems in the transition to graduate medical education programs; the AAMC's reduced schedule residency questionnaires; the three-year curriculum study; health manpower legislation, and housestaff issues.

On the latter two issues the most important aspect of the discussion was an examination of the Board's handling of the OSR's previous resolutions. The Officers had decided that the responsible course was to forward the OSR's dissent to the AAMC Brief on the recognition of house officers for collective bargaining to the NLRB, but to continue to press for recognition of their ideas on health manpower within the forums of the

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Association. The officers received a vote of confidence for their decisions from the OSR Board. They expressed the view and intention that this action represented the end of the rift between the OSR and the AAMC and pledged to work within the Association on all future issues. They were heartened by the reception they received at the Officer's Retreat, the recognition given by the Chairman that they had not been properly consulted on the housestaff collective bargaining issue, and the pledge of the Chairman to ensure better collaboration in the future.

Toward the goal of better communications with the rest of the AAMC, the OSR proposed two changes in the governance structure: 1) that they be given a second vote on the Executive Council, and 2) that the OSR Chairperson be seated on the Association's Executive Committee. Some Board members, while cautioning that the Association's governing structure ought not be tampered with lightly, indicated that the first proposal would be acceptable to them if cast in terms of achieving greater continuity in OSR participation on the Executive Council, that is, if the OSR returned to a system of electing both a Chairman and a Chairman-elect, who would assume the Chairmanship in the second year of office, it would be advantageous to the AAMC to have both seated and active in Executive Council affairs.

There was somewhat less enthusiasm for the second proposal, it being many members' perception that the effectiveness of the Executive Committee required it to be a small and easily accessible group. Problems of communication with the OSR could be handled by including the Chairperson in the conference calls where an issue of substantial importance to the OSR was being discussed.

VII. <u>Adjournment</u>

The meeting was adjourned at 1:15 p.m.

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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

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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.

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