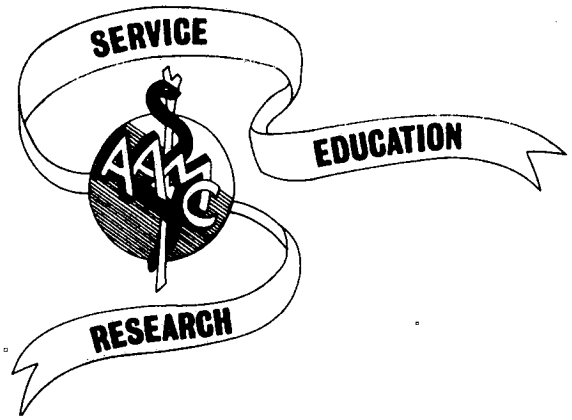
Miss Littlemeyer



AGENDA
FOR
COUNCIL OF DEANS

ADMINISTRATIVE BOARD

THURSDAY, JUNE 24, 1976

8:00 AM - 1:00 PM

EDISON ROOM
WASHINGTON HILTON HOTEL
WASHINGTON, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle, N. W.

Washington, D. C.

FUTURE MEETING DATES
1976

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

AAMC Annual Meeting
San Francisco Hilton Hotel

November 11-15, 1976

FUTURE MEETING DATES
1977

COD Administrative Board----------January 13, 1977
Executive Council----------January 14, 1977

COD Administrative Board----------March 31, 1977
Executive Council----------April 1, 1977

COD Administrative Board----------June 23, 1977
Executive Council----------June 24, 1977

COD Administrative Board----------September 15, 1977
Executive Council----------September 16, 1977

COUNCIL OF DEANS
ADMINISTRATIVE BOARD
June 24, 1976
8 a.m. - 1 p.m.
Washington Hilton Hotel
Edison Room

AGENDA

JOINT COD/CAS DISCUSSION
11:30 a.m. - 1 p.m.
Washington Hilton Hotel
Hamilton Room

Accreditation in Medicine--Role, Function & Challenges

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

March 25, 1976
9 a.m. - 1 p.m.
Kalorama Room
Washington Hilton Hotel

PRESENT

(Board Members)

J. Robert Buchanan, 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.
Clayton Rich, M.D.
Chandler A. Stetson, M.D.
Robert L. Van Citters, M.D.

(Staff)

Robert J. Boerner
John A. D. Cooper, M.D.
H. Paul Jolly, Ph.D.
Joseph A. Keyes
Hugh Morrison
Diane Newman
Jaimee S. Parks
James R. Schofield, M.D.
Emanuel Suter, M.D.
Bart Waldman
Marjorie P. Wilson, M.D.

(Guests)

Ivan L. Bennett, Jr., M.D.
Thomas A. Rado, Ph.D.
Richard S. Seigle

I. Call to Order

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

II. Chairman's Report

Dr. Gronvall mentioned that a decision had been reached by the NLRB on the question of housestaff unionization and that copies of the decision would be distributed.

The Chairman gave an overview of the final plans for the COD Spring Meeting, April 25-28 in Clearwater, Florida. He reminded the Board of the change in schedule with sessions opening on Sunday evening. This change was necessitated by the fact that the keynote speaker was

unavailable on Monday morning. In addition to the opening address on governance issues at the medical school-teaching hospital interface, five "work items" of current and future importance to medical education have been selected and will be announced in the final program.

Dr. Gronvall announced the formation of a Task Force on Student Financing to be chaired by Bernard Nelson. Drs. J. Robert Buchanan and Robert Tuttle will sit on the Task Force as COD representatives.

III. Minutes of Previous Meeting

The minutes of the January 14, 1976 meeting of the Administrative Board were approved as circulated.

IV. Executive Council Actions

A. Report of the Task Force on Continuing Medical Education

Dr. William Luginbuhl, Chairman of the Task Force outlined the report. The Task Force decided that it was not its role to develop solutions to the problems of continuing medical education, but rather to delineate the problems and the role of the Association in this field and to recommend a process for discharging that role in the future.

The Task Force recommended in its report that the Executive Council authorize: 1) the creation of a Group on Continuing Medical Education; 2) the appointment of an ad hoc Committee on Continuing Medical Education to recommend to the Executive Council policies for promulgation at the national level; and 3) assignment of staff resources to continuing medical education programs.

Dr. Gronvall mentioned that there had been considerable discussion of the formation of a group outside the Association to deal with the problems of continuing medical education. Both Drs. Luginbuhl and Suter said that they believe that if the Association acted within the calendar year to form such a group within the AAMC, that the constituency would be satisfied and the formation of an outside group could be averted.

Most of the discussion which followed focused on the first recommendation of the formation of an AAMC Group on Continuing Medical Education. The general mood of the Board was not to proliferate a complex structure of the Association by the addition of any more groups regardless of purpose or sponsor. On the other hand, continuing medical education

was recognized as a very important area, deserving AAMC attention. Thus we need to be actively working on the issue and recommendations 2 and 3 are appropriate to accomplish this objective. The provision of some forum in which the AAMC constituents could share views and information is also appropriate but whether this should take the form of a separate AAMC Group or a section of the existing Group on Medical Education or some other organizational structure, the Board was unable to judge at this time. It was the consensus of the Board, however, that those involved with continuing medical education should be sent a strong signal that the AAMC intended to be responsive to their interests and the recommendations of the Task Force even though the precise nature of the organizational structure could not be determined immediately.

Action:

The Board approved recommendations 2 and 3 and endorsed providing a group with an appropriate forum but recommended that the name and structure of such a forum be referred to the AAMC Executive Council Committee on Governance and Structure.

B. LCME Membership in the Council on Postsecondary Accreditation

The Council on Postsecondary Accreditation (COPA) is a national, nonprofit organization. Its major purpose is to support, coordinate, and improve all nongovernmental accrediting activities conducted at the postsecondary educational level in the United States.

The LCME voted to join COPA for an annual membership fee of $750.

Action:

The Board approved the recommendation that the Executive Council ratify the action of the LCME to join COPA for an annual fee of $750.

C. LCME Guidelines for Functions and Structure of a Medical School

At the January 1975 meeting of the LCME, the members expressed the opinion that a need exists for guidelines to address many issues more specifically than does the "Functions and Structure" document, but consistent with it. At the March 1975 meeting,

the Liaison Committee appointed a subcommittee to draft guidelines and instructions for staff and survey teams for the implementation of policies established in "Functions and Structure of a Medical School."

The Liaison Committee on Medical Education, at its January 1976 meeting, reviewed and accepted the document, "Guidelines for Functions and Structure of a Medical School," which is not new policy but rather an amplification of policies already set forth. The Liaison Committee has asked that the AAMC Executive Council and the AMA Council on Medical Education review these guidelines. The CME discussed these guidelines at its March 1976 meeting and its comments were indicated in the draft document presented to the Board.

Dr. James Schofield gave an overview of the development of the document and asked the Board for its review.

The Board voted to support the document but recommended some editorial changes.

A policy question was raised in regard to a paragraph having to do with graduate education. Some members were concerned that the paragraph should be broadened to include the idea that academic renewal and stimulus should be provided for graduate students, but that there may be other ways of doing this than "Advanced degree programs in basic medical sciences". The Board recommended that "post-doctoral programs" be mentioned along with the advanced degree programs as a means of providing such opportunities. The Board also recommended that the phrase "the necessity of graduate programs" read "the importance of graduate programs".

The Board recommended that the phrase "appointment of committees" be changed to "designation of committees" in recognition of the variety of means that committees might be established.

Richard Seigle, OSR Chairperson, commented on the paragraph on student representation on committees. The OSR felt that the words "responsible mature" in description of medical students to sit on committees was inappropriate and asked for deletion of the two words. It was also suggested that the word "membership in committees" be changed to "participation in committees". The Board agreed and recommended the changes. The Board also recommended that the student participation paragraph be incorporated in the paragraph dealing entirely with medical school governance.

There were several other revisions discussed and discarded because they would have made the guidelines more suited to specific incidents than general occurances.

Action:

The Board endorsed the document with the above mentioned editorial changes.

D. Criteria for "Subscribers"

At its September 1975 meeting the Executive Council agreed that a "Subscriber" category should be established to enable institutions not qualifying for AAMC membership to receive AAMC memoranda, publications, and other informational mailings. At that time, it was primarily contemplated that new and developing medical schools would belong to this category prior to receiving provisional accreditation and, therefore, being eligible for membership. Some mention was also made of allowing remote educational sites, AHECs, and multi-campus medical schools to take advantage of this subscription. The Executive Council established a subscription fee of $500 per year, which is equivalent to the fee charged hospitals becoming Corresponding Members.

In establishing criteria for subscribers, several issues arise:

1. Since the Association can restrict the mailing of sensitive memoranda to members only, is there any reason not to open up the subscriber category to any institution or individual interested and willing to pay the subscription fee?

2. What services should the Association provide routinely to multi-campus medical schools who pay dues as one institution? Would it be fair to charge an additional subscription fee for providing the AAMC's informational resources to the satellite administrative units?

3. When a component part of a member medical school requests subscriber status, should the permission of the medical school dean be required?

It was recommended that the Executive Council adopt the following criteria for "Subscribers":

1. These subscriptions be open to any institution, organization, or individual demonstrating a commitment to

medical education and not eligible for any class of voting membership.

2. Any institution which is part of a member medical school (or individual affiliated therewith) must have the approval of the dean of that medical school.

3. All Subscribers shall be approved by the Executive Council prior to attaining Subscriber status.

4. Benefits of this subscription shall be:

   a. Journal of Medical Education

   b. President's Weekly Activities Report

   c. COTH Report

   d. Student Affairs Reporter

   e. Directory of American Medical Education

   f. Assembly Memoranda (other than questionnaires and confidential "members only" communications)

   g. Other memoranda or communications of general interest to these institutions and individuals

It was also recommended that the Executive Council specify that satellite campuses of multi-campus medical schools who wish to receive these services should be required to become Subscribers.

Action:

The Board approved the recommendation that the Executive Council adopt the listed criteria for Subscribers.

E. Approval of Subscribers

Following the approval of criteria, the Board was asked to recommend to the Executive Council approval of Subscriber status for East Carolina University School of Medicine and Texas A & M/Baylor College of Medicine.

Action:

The Board recommended that the Executive Council approve Subscriber status for both schools.

F. Admission of Women to Medical School

At its January 1976 meeting the OSR Administrative Board suggested that the Executive Council consider revising the policy statement appearing in the "Green Book" addressing "Should More Women Be Encouraged to Enter The Medical Profession?".

The staff redrafted this issue in the form which is used in the Green Book. It was felt desirable to redefine the issue as well as to update the Association's policy and activities in this area. The policy statement appears below:

PRESENT STATE OF POLICY DEVELOPMENT:

The Association encourages all students, men and women alike, who are considering attending medical school to evaluate carefully both their qualifications for and commitment to a career in medicine. The Association strongly opposes the use of admissions policies which discriminate against women and is committed to working toward removing any barriers which make it more difficult for women to have a successful career in medicine.

The OSR Administrative Board suggested, and the COD Board agreed, that the statement should be revised to reflect what the Association promotes rather than what it opposes. Dr. Gronvall charged Dr. Van Citters and Mr. Seigle to develop a proposed policy statement for consideration by the Executive Council which would remedy this concern.

G. Governmental Cognizance of the Institutional Well-Being of Academic Medical Centers

The Agenda book contained the material appearing as Appendix A of these minutes "Governmental Cognizance of the Institutional Well-Being of Academic Medical Centers". This document discusses the impact of the increasing involvement of the Federal Government with all aspects of medicine and health and the parallel development of greater emphasis on specific federal purposes in the awarding of support and more regulation in the implementation of the programs. This situation has led to considerable concern about the impact on the institutional well-being of academic medical centers.

Action:

The Board recognized the seriousness and complexity of the problem and encouraged the Association to continue its pursuit of a conclusion.

H. OSR Accreditation Pamphlet

The OSR presented the pamphlet appended to these minutes to the COD Board for approval. The pamphlet will be distributed to OSR institutional representatives.

Action:

The Board approved the document as written.

V. Discussion Items

A. IOM Social Securities Studies, Medicare/Medicaid Reimbursement Policies

Dr. John Gronvall, who had chaired a task force representing each of the Councils for the review of the study, presented a report of the task force deliberations and their recommended positions. The task force recommended support of the report as the major AAMC reaction, but indicated a number of specific areas deserving more detailed consideration and perhaps a different position than recommended in the report. These were:

Commission to regulate specialty distribution of physicians.

The IOM recommended the appointment of a new quasi-public 13 member commission to monitor specialty distribution and determine slots for each specialty. Enforcement would be via LCGME and CCME as extension of accreditation process.

The recommended response included the following basic points:

1) LCGME is not an enforcement arm for Federal government; accreditation is a quality review of individual programs.

2) LCGME and CCME could provide advice which Secretary HEW could use to enforce.

3) Previous AAMC supported S.992 approach would conform to CCME--Secretary HEW mechanism.

4) If new commission appointed, we prefer S.992 composition to give majority from professional organizations and include Federal agency officials as ex officio (IOM makes majority "from other sectors").

However, current trends might indicate that enforcement mechanisms are not needed, only monitoring. NIRMP data shows responsiveness of the present system.

The Board agreed.

Moratorium on Residency Slots.

The IOM recommended a freeze on residency slots as of July 1, 1975 and a moratorium on any increases except in "contract physician" areas ("family practice, general internal medicine and general pediatrics").

The recommended response included the following:

1) This action is unnecessary. Recent NIRMP data show that trend is going this way anyhow.

2) It is unworkable--a bureaucratic nightmare to administer.

3) It is diversionary. We should put our energy in constructive long term solutions.

The Board agreed but urged that the emphasis on the AAMC response should be positive, "let's get on with the job of doing it right", rather than a negative one, "what is proposed is hard to administer".

Reimbursement Alternatives

1. The Cost-Based System

   The AAMC can support but must work for adequate definitions of two important terms: A) Cost--which must include facilities costs, clerical support costs, etc., necessary to the creation of the teaching environment. It should not be limited to 105% of direct salaries plus fringe benefits. B) Volunteer Physicians--as presently written it would exclude anyone paid any amount.

2. The Fee-Based System

   The AAMC is pleased to have fees as an allowable alternative but a difficult issue is presented in the recommended phase out over a 2 year period of "cost reimbursement for supervisory and teaching services" except for a Director of Medical Education and Administrators of specialized units.

One alternative AAMC response would be to accept this 3/4 loaf, recognizing that to many people the present system appears to be double billing. Because this may work a serious financial hardship on some member institutions, such an approach might not be feasible. A second alternative would be to argue that there are three distinct physician services in teaching hospitals which must be recognized and reimbursed:

1) Direct, personal medical service (in-patient & OPD)

2) Administration and supervision of the hospital as an organization

3) Physicians services for teaching programs (undergraduate, graduate, CME)

More details of the actual impact of the phase out might need to be gathered. The Board tended to favor the second alternative.

An IOM recommendation that mixed and geographic settings should not be accepted for different payment methods in the same hospital appears to be very retrogressive and would severely penalize those institutions making strenuous efforts to develop "one class" of service, but who were still in a transition phase. The Board agreed that we should reject this recommendation, at least to the extent that there is no phase out period or timetable.

3. Unified Method

While this appears to be an accommodation to the fact that some centers now operate according to this method, the AAMC should not endorse it because it undermines the concept of housestaff as students and has few if any compensating features. Our position should be silent acquiesence rather than public opposition. However, its disadvantageous features should be made known to our constituents.

Foreign Medical Graduates

The IOM recommendation is that existing incentives for physician immigration should be eliminated and that medicine should be removed from the Department of Labor Schedule A as a shortage profession, are both in agreement with previous AAMC positions and are supportable.

Ambulatory Care

The IOM recommendation that financing mechanisms be changed to more equitably support ambulatory care so that medical schools and hospitals would find it easier to finance primary care training programs is a very positive and supportable development from the AAMC perspective.

Conclusion

On balance, the AAMC should support the report, while working to clarify and perfect its basic recommendations.

B. Report of OSR Administrative Board Actions

Thomas Rado, OSR Vice Chairperson, reported on an OSR resolution which recommends a second OSR vote on the Executive Council. At present, the Chairperson is the only voting member of the OSR on the Executive Council, with the Vice Chairperson present as a non-voting member. Various alternatives for accomplishing the addition of a vote were discussed and it was recommended that a committee be established of both COD and OSR members to pursue a solution to the problem.

Dr. Gronvall appointed Dr. Krevans to work with him and the student officers on this matter.

VI. Adjournment

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

GOVERNMENTAL COGNIZANCE OF THE INSTITUTIONAL WELL-BEING OF ACADEMIC MEDICAL CENTERS

THE ISSUE

What are the potential consequences of the lack of an explicit responsibility or concern within the federal government for the institutional well-being of academic medical centers?

BACKGROUND

The steadily increasing involvement of the federal government with all aspects of medicine and health has been paralleled by greater emphasis on specific federal purposes in awards of federal support and more regulation in the implementation of programs. Neither in the Congress nor in the Executive Branch is there by inclination or designation a focal point which assures consideration of the impact of federal legislation, programs and regulations on institutions qua institutions. This situation becomes more obvious and serious as the interdependence of the government and the academic medical centers deepens. Numerous illustrations of the deleterious consequence of this circumstance can be cited:

- Passage of amendments to the Social Security Act without sufficient attention to their effect on physician manpower and reimbursement of teaching hospitals.
- Expansion of categorical centers as a major programming device of the NIH Institutes.
- Eligibility for capitation awards dependent on acceptance of increasingly costly and intrusive conditions.
- Imposition of significantly more restrictive guidelines on use of General Research Support Grants and attempts to terminate that program.
- Proposals to place ceilings on indirect cost reimbursement.
- Inconstancy of federal responsibility for research manpower.
- Imposition of expensive and complicated administrative regulations as a part of grant and contract compliance.

The result is an array of purposeful but uncoordinated and costly programmatic challenges focused on the academic medical centers. While the objectives sought are certainly laudable, the question must be raised as to whether this is the most effective approach to their attainment.

POSSIBLE COURSES OF ACTION

It is almost axiomatic that a successful strategy for improving the present situation cannot be limited to one or two measures and may well require repeated efforts for some time. Although more adequate funding for federally sponsored activities is the most obvious need, the nature of the terms and conditions accompanying the funds has become equally important.

Therefore our efforts should be planned so as to encompass both the financial and administrative aspects of the problem. It must also be recognized that despite a general mutuality of interests, there will always be the possibility that on specific issues or activities, the mission of the federal agencies and the purpose of the institutions will not be identical or perhaps even compatible.

Among possible courses of action are:

1. Seminars with Congressional and Administration officials. The specific objective would be a better understanding of the characteristics of contemporary academic medical centers including their capabilities and limitations, the determinants of their evolution, and our concerns for their vigor and integrity.

2. Discussions with HEW Secretary and Assistant Secretary for Health to consider the identification of an official or office which could serve at least an ombudsman's role for academic medical centers.

3. Renewal of efforts to convince the Legislative and Executive Branches of the justification for some funds with reasonable flexibility in order to offset the "stop and go" effect of a largely project-oriented approach of federal funding.

4. Perhaps, even, a requirement for filing of an "institutional impact statement" as a part of the development of legislation and programs.

ORGANIZATION OF STUDENT REPRESENTATIVES

ACCREDITATION PAMPHLET

FOREWORD

For obvious reasons, medical school accreditation is one of the most important functions of the Association of American Medical Colleges and the American Medical Association. Unfortunately, in past years, students have been relatively unaware of the procedures involved in medical school accreditation and the outcomes of accreditation reviews of their own institutions.

It is the opinion of the Organization of Student Representatives that medical students should be able to participate optimally and to provide input to the accreditation review of their medical schools. Since few students experience more than one accreditation site visit (they occur at intervals of up to seven years), the OSR felt that background information should be developed which would enable students to effectively participate in the accreditation process.

With this purpose in mind, the OSR Administrative Board began in 1973 to collect information about medical school accreditation and compiled the opinions of many medical students who had actually participated in accreditation site visits. The culmination of these efforts is this handbook which we hope will assist you and your student body in presenting a concise and informed consensus of student concerns at your medical school to the accreditation site visit teams.

As with any document which is based in part on personal opinions, there may be omissions or errors in judgement. We hope that after you have taken part in an accreditation site visit, you will give the OSR feedback regarding information we may add to future editions of this handbook.

Finally, we hope that this handbook will aid you during the accreditation of your medical school and that medical education will consequently be optimized for future medical students and for health care in general.

Dan Clarke-Pearson, M.D.
Past OSR National Chairperson
September, 1975

Explanation of Procedures and Student Roles

Medical school accreditation is the process by which the public is assured that medical school graduates are qualified to be granted the M.D. degree and to provide, when fully trained, optimum quality health care to society. It also guarantees to medical students a sound and valid educational experience. The organization which is charged with the responsibility of accrediting medical schools is the Liaison Committee on Medical Education (LCME).

The LCME was formed in 1942 as a joint committee of the AAMC and the AMA, and its membership consists of six representatives from AAMC, six representatives from AMA, and two public representatives. The operational structure of the LCME and the process by which schools are accredited is complex. Essentially, accreditation of a medical school is based upon careful study of detailed background and descriptive materials submitted by the school to the LCME, a site visit of the school by an ad hoc LCME accreditation team, and a written report submitted to the LCME by the site visit team.

The team usually consists of four individuals whose composite backgrounds include expertise gained at a variety of medical schools in major areas of medical education such as basic science, clinical education, medical school administration, and student affairs. Membership of each team always includes at least two individuals who have participated in many accreditation inspections and have a broad knowledge of and experience with the process. One member of the site visit team is designated as the secretary, and this individual is primarily responsible for compiling the opinions and judgements of the team about the school into a report which is reviewed by the other team members. The report is then submitted to the LCME secretary who distributes it to the LCME, the

AAMC Executive Council, and the AMA Council on Medical Education (about 45 individuals) for review and reaction. The spectrum of possible actions the LCME can take in response to the review of the site visit report and any additional background material submitted by the school ranges from denial of accreditation to the granting of full accreditation for a period of seven years. Usually, the actions taken by the LCME fall somewhere in between, and accreditation may be granted for a portion of the maximum seven years with progress reports due at specified intervals. Final accreditation decisions reached by the LCME are ratified by the Executive Council of the AAMC and the Council on Medical Education of the AMA for legal licensure purposes.

Site visit teams generally spend three days interviewing members of the faculty, administrators, and all departmental chairmen. Student representatives are usually invited to spend an hour or more with the site visit team discussing aspects of the educational program which are of particular concern to the student body. Since a primary function of accreditation is to insure medical students a valid educational experience and since the LCME's accreditation review and the subsequent report submitted to the medical school can have a major impact on a school's educational program, it is essential that students optimally participate in the process.

As a student representative, you should have been informed of the pending site visit of your school far enough in advance to prepare for a concise but thorough interview with the site visit team. In the following segments of this pamphlet, suggestions are made as to how to organize background materials and to obtain a student consensus about important aspects of the educational program at your school so that you can present representative student views to the accreditation team.

Guidelines for Implementation

There are, of course, a variety of ways to determine what issues your fellow students would most like to have considered by the LCME accreditation team. You may wish to meet with representatives of each class or with an already existing student committee to discuss the pending site visit. Class officers and representatives of American Medical Student Association (AMSA), Student National Medical Association (SNMA), and the Student Business Session of AMA might serve as resource people and coordinators when you are beginning your plans for gathering student opinions. Since the accreditation process ultimately affects all medical students, this initial attempt to gather "grass-roots" input should be as broadly-based as possible.

After initial discussions, several options are available; among them:

1. Disseminate a concise but thorough questionnaire, polling students about the pros and cons of their educational program. (You should be prepared to cite the percentage of the student body responding.)
2. Hold class meetings to discuss student concerns and request each class to submit reports delineating problems and assigning priorities to them.
3. Choose several representatives of each class to form a committee which will identify the issues of highest concern to the student body.

Once issues have been identified, a small working group (which should include the six to eight students who will actually meet with the site visit team) can begin to organize and develop student input. Discussion with the student affairs officer of issues of concern which have surfaced during the gathering of student opinion may be beneficial at this point in terms of internal communication.

You should preferably organize your input in the form of a written report, and this should be received by the dean's office at least one month in advance of the site visit so that it may be forwarded to the LCME with other materials compiled

by the dean and department chairmen. In order to keep the OSR informed of student concerns on a general level and also to provide feedback as to how this system is working, you may wish to send a written evaluation of your experience with the accreditation process to the OSR National Chairperson.

Some guidelines in regard to written background materials are as follows:

1. Keep background materials *concise*. The LCME team reads thick volumes of materials about each school before its visit, and concise summaries of issues of concern to students will have a greater impact than will a lengthy or repetitive exposé.
2. Stick for the most part to *factual* support materials. If the counseling system is ineffective at your school, and this is a major concern of the student body, provide a factual description of the existing system pointing out its weaknesses. Anecdotal data may be helpful but ensure that such data is representative.
3. *Focus* on key issues. Selection of the concerns which are most vitally linked to the structure and content of the education program at your school is more effective than an "a through z" listing of minor deficiencies.

Generally the site visit team will schedule a meeting with student representatives of 1-1½ hours in length. Since each major departmental chairman is usually alloted only an hour or less--sometimes with only half of the team present--this time allotment should be sufficient if your representatives have prepared in advance. If it is apparent during the meeting that this time is not sufficient, you may wish to request an extension or an additional meeting. Keep in mind, however, that the team has a very compact schedule, and your requests for additional time may not be realistic.

Review Factors for Accreditation Site Visit

In preparation for the site visit, you may wish to consider the following student-related areas as possible foci for your discussions with the LCME accreditation team. This list is not all-inclusive; likewise, many of the topics listed may not be particularly significant in an evaluation of your own school's educational program.

EVALUATION: Methods of basic science and clinical evaluations, examination and grading systems, evaluations for residency application, adequacy of feedback from instructors, record-keeping system and accessibility of records, opportunity for student review of evaluations, utilization of NBME scores.

TEACHING: Quality of instruction, academic assistance programs, relevance and flexibility of curriculum, self-instructional programs, advising system, exposure to out-patient and emergency room services, primary care program, length of degree program, student/patient ratio, elective programs, student participation in curriculum development, integration of preclinical and clinical curriculum, relevance of clinical services performed by students, innovative teaching programs, faculty/student ratio.

MINORITIES AND WOMEN: Socio/economic heterogeneity of student body, minority and female enrollment, recuitment and retention programs, adequacy of on-call rooms and other facilities for women, counseling and support programs for women and minorities, role models.

STUDENT AFFAIRS AND ADMINISTRATION: Availability of personal counseling, general accessibility of student affairs personnel, student representation on committees, student government, student participation in institutional governance.

OSR REPRESENTATION ON EXECUTIVE COUNCIL

At its January meeting, the OSR Administrative Board requested that the OSR be granted a second voting seat on the Executive Council. The board members felt that increasing representation on the Council would enhance OSR's credibility both within and outside the Association. They pointed out that their constituency frequently questioned whether their single vote on the Executive Council was indicative of the Association's level of receptivity to medical student views. The OSR Administrative Board brought their request to the COD Administrative Board and stressed that increasing the number of student votes on the Executive Council would be a gesture viewed very positively as reflective of the AAMC's commitment to medical students.

The COD Administrative Board discussed the OSR request at its January and March meetings. During those discussions, COD members expressed concern about the proliferation of requests from various groups within and outside the Association for changes in the governing structure of AAMC and composition of the Executive Council. On the other hand, it was generally agreed that the addition of a second seat on the Executive Council would augment the efficiency of the Council's deliberations if a mechanism could be worked out that would guarantee a greater degree of continuity in OSR participation on the Executive Council.

In March, a joint committee of COD and OSR board members (Dr. Gronvall, Dr. Krevans, Mr. Seigle, and Dr. Rado) met with AAMC staff to discuss ways by which both goals--increasing OSR Executive Council representation and ensuring continuity of that representation--could be met. The joint committee agreed that any system which would ensure continuity would require that at least one of the two Executive Council representatives had served in that capacity the previous year. It was acknowledged that while such a system would guarantee continuity, it would, by definition, limit the infusion of new people with new ideas into leadership positions and might foster the self-perpetuation of leadership which was not the most representative of the membership. It was also acknowledged that it is often difficult for medical students to commit themselves for a two or three year period of service although such a commitment would be necessary in a system designed to ensure continuity.

It was agreed that the system that would work best for the OSR and for the Executive Council would strike a balance between the need for continuity within the Executive Council on the one hand and the negative effect within the OSR if their leadership structure were inflexible to such an extent as to make it virtually impossible for new people to become involved in the Organization. The committee developed several options for consideration by the OSR and COD Administrative Boards, and these are outlined below. It was understood that any recommendations regarding a change in the composition of the Executive Council would require a Bylaws change and would thus require review by the Committee on Governance and Structure and approval by the Assembly. The options for OSR and COD consideration are:

I. *The OSR would elect a Chairperson-Elect who would automatically assume the office of Chairperson in the second year. Both the Chairperson and Chairperson-Elect would be voting members of the Executive Council.* With this option, the OSR would return to a system it once had and which the three

councils currently have. It would require that the Chairperson-Elect be a 1st, 2nd, or 3rd-year student so that he or she would be an institutional representative when serving as Chairperson.

While this option would provide optimum continuity, it could cause problems for the OSR if the Chairperson-Elect were not functioning well. In order to prevent an individual who had not functioned adequately in the first year to automatically assume the office of Chairperson and to continue as an Executive Council member, it would be advisalbe to include a mechanism which would allow for the removal of the Chairperson-Elect (e.g., the Administrative Board be empowered to prohibit the Chairperson-Elect from serving a second year by a two-thirds vote).

II. *The OSR would continue to elect both a Chairperson and Vice-Chairperson for one year terms, but neither would sit on the Executive Council. Two representatives would be elected specifically to serve on the Executive Council, and each would be elected in alternate years for two-year terms. The two Executive Council representatives would be members of the OSR Administrative Board in the same capacity as the Representatives-at-Large currently serve; no further expansion of the OSR board would be required.*

With this system, one Executive Council representative each year would have had a year's experience of serving on the Council. The potential problems associated with an individual who is not functioning well to automatically continue into a second year of office are not as great with this option as with the first option since the individual would not be continuing in both capacities of Chairperson and of Executive Council representative. The potential drawback of this system would be the decentralization of OSR leadership since neither of the traditionally highest-ranking officers of the OSR would be members of the Executive Council. This system might also cause communication problems since it would not always be clear who should be consulted on matters relating to the Organization between meetings.

III. *The Chairperson and the Immediate-Past-Chairperson would serve on the Executive Council.* In order for AAMC to maintain its tax-exempt status, this option would have to include the provision that the Chairperson be a 1st, 2nd, or 3rd-year student when elected so that he or she would be an institutional representative when serving on the Executive Council as Immediate-Past-Chairperson. It is likely that the Chairperson would be a third-year student in order to have the background and experience to assume this office. This could present a problem in that the time commitments during the third year are usually such that it would be difficult for a third-year student to also serve as OSR Chairperson.

IV. *The Chairperson and two Representatives-at-Large would sit on the Executive Council, but only the Chairperson and one Representative-at-Large would vote. Each Representative-at-Large would be elected, in alternate years, to two-year terms, and the Representative-at-Large in the second year of office would vote on the Council.*

This option would provide continuity without eliminating the possibility for new people to become involved in leadership roles within the Organization. It would also permit the Chairperson to be an Executive Council representative, and would therefore not cause the potential problems mentioned under Option II. The potential drawback with this system involves the financial and operational considerations related to the further expansion of Exeuctive Council composition.

V. One alternative in addition to the ones outlined above would be to retain the status quo. Each of the other options is based upon modification of the present system, and before modifications are recommended, consideration should be given to the advantages and disadvantages of the current system. At present, the OSR has two members on the Executive Council. Although only one member votes, both are given the privilege of the floor and both are included in Executive Sessions. While it may be advantageous in terms of OSR's credibility as viewed by the student constituency to increase their voting representation on the Executive Council, it is very unlikely that an Executive Council decision would ever be altered by one vote.

RECOMMENDATION

That the OSR Administrative Board consider these alternatives and recommend its choice to the COD Administrative Board which in turn will make a recommendation to the Executive Council.

INSTITUTIONAL GOVERNMENTAL LIAISON OFFICERS

Now and for the forseeable future both state and federal governments appear to have an increasingly intimate and influential role in the activities and institutional health of academic medical centers. While we have been aware of this situation, we do not appear either to be as keenly aware or as effective in our response as those with whom we are in a competitive position in the resource allocation process. Compare, for example, the relative success of the higher education community the most recent appropriations bill with our own measure of success. This recognition suggests that it is appropriate for us to begin thinking collectively regarding approaches which would enhance our prospects for success in this arena.

A first step might be to specify the roles and responsibilities of 1) the staff and officers of the AAMC, and 2) the roles of the constituent institutions themselves.

It seems important to recognize that the AAMC as an organization has several important, but on the whole limited, functions. These may be tentatively listed as:

1) Monitoring national developments;

2) Communicating important developments to the membership;

3) Facilitating the development of strategies and positions on issues by the community;

4) Representing the academic medical community in hearings and other such forums.

This is to be contrasted to the matter of contacting individual legislators and persuading them that it is in the public interest and that of their own constituents to support or oppose measures impacting upon medical centers. This function can be done far better by the schools themselves. In this regard, the response of the schools to dean's memoranda suggesting the importance of contacting legislators on various issues has been quite spotty. Occasionally, a school's response has been excellent. Generally, however, the result is either no response, or a poorly prepared one. We are informed that this is putting us at a substantial disadvantage with competing interests.

One approach for enhancing the effectiveness of the institutions in this arena has been the appointment of institutional governmental liaison officers. Such a person, generally a faculty member or a ranking administrative staff member has the responsibility for monitoring relevant governmental activity, communicating with the appropriate institutional officials or faculty and orchestrating the institution's response. There are various

models of this which are essentially multi-institutional arrangements of groups with a defined community of interest, e.g., the New York deans, the Pennsylvania deans.

We have been particularly impressed with the Pennsylvania deans' model. The deans meet periodically, a staff member of one school serving as executive secretary over an extended period while the chair of the group rotates. On national legislative issues, the deans meet as a group, agree upon strategy, precede their visit to the Hill with one to AAMC, meet with the entire delegation at once (the interchange among the legislators is an effective tool of persuasion) and debrief the AAMC staff upon their return.

The role of institutional governmental liaison may be even more significant at the state level than at the national, since at present the AAMC has little capability to assist in this area.

Last year, Fred Ramsay, Associate Dean and Director, Office of Governmental Liaison at the University of Maryland School of Medicine, queried each of the schools in an attempt to develop a roster of such officers. A summary of the responses appears on the attached sheet. It is our perception that the number of such positions has increase substantially over the past year. We believe it timely for the AAMC to conduct a new survey to learn the names and identities of such officials.

Recommendation: That the Board consider the matter of effective representation of medical center interests before the national and state governments, react to the suggestion that a survey to learn the identity of liaison officers be undertaken and provide additional recommendations and suggestions as appear appropriate.

LEGISLATIVE & GOVERNMENTAL LIAISON

LIAISON PERFORMED BY:	TOTALS	SCHOOL (IDENTIFIED BY NUMBER FROM THE ATTACHED ROSTER)
ONE OR MORE PERSONS EMPLOYED FULLTIME BY THE MEDICAL SCHOOL WITH LIAISON FUNCTION AS THEIR SOLE OR PRIMARY TASK	2	86, 87
THE DEAN	8	44, 45, 46, 47, 48, 49, 50, 51
ONE OR MORE PERSONS EMPLOYED BY THE MEDICAL SCHOOL WHO HAVE PRIMARY RESPONSIBILITIES ELSEWHERE (DEVELOPMENT OFFICE, ACADEMIC AFFAIRS ETC...)	20	7, 8, 9, 10, 21, 23, 24, 26, 27, 28, 31, 32, 33, 37, 36, 41, 42, 43, 57, 85
ONE OR MORE PERSONS EMPLOYED OUTSIDE THE MEDICAL SCHOOL (CHANCELLOR'S, PRESIDENT'S OFFICE ETC...) BUT ASSIGNED MORE OR LESS SPECIFICALLY TO THE MEDICAL SCHOOL AND/OR HEALTH LEGISLATION	14	4, 5, 6, 12, 13, 15, 16, 18, 20, 22, 23, 29, 39, 40
ONE OR MORE PERSONS EMPLOYED OUTSIDE THE MEDICAL SCHOOL (AS ABOVE) BUT WITH NO SPECIFIC ASSIGNMENT TO THE MEDICAL SCHOOL AND/OR HEALTH LEGISLATION	15	1, 2, 3, 14, 17, 25, 30, 34, 35, 38, 52, 53, 54, 55, 56
OTHER	1	19 (COMMITTEE)
NO ONE	27	58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84.
NO RESPONSE	28	
TOTALS.	114.	

Proposed Talmadge Bill Testimony

The Association of American Colleges is pleased to have this opportunity to testify on the "Medicare-Medicaid Administrative and Reimbursement Reform Act" (S. 3205) of 1976. The Association represents 400 of the nation's major teaching hospitals, all of the nation's medical schools, and 60 academic societies. Thus, the Medicare and Medicaid amendments proposed in S. 3205--concerning administrative, provider reimbursement and practitioner reimbursement reforms--are of a direct interest and concern to the Association's members.

For several months, the Health Subcommittee staff of the Senate Finance Committee has been most generous in discussing general concepts and tentative provisions of S. 3205 with Association representatives. These meetings were informative and, we believe, of mutual benefit. For this dialogue and for the staff's concern in developing amendments to strengthen the Medicare and Medicaid programs, the Association expresses its appreciation to the Subcommittee and its staff.

The Association is well aware of the fact that spending for health care -- as a result of general economic inflation, increased service availability, improvements in service quality, growth and changes in population, and increased per capita utilization -- has increased more rapidly in the past two decades than have most other segments of the economy. This fact has focused consumer, industrial, governmental, and

provider attention on the nation's health care expenditures. In recent legislation -- such as P.L. 92-603 and P.L. 93-641 -- the Congress has attempted to establish programs and policies which will help stimulate a more efficient and effective health industry. The Association hopes that present legislative efforts will attempt to further that objective of stimulating a more efficient and effective health industry.

Of equal concern to this Association is the objective of continually ensuring that quality patient care is not sacrificed as a result of program economy measures. Members of the Senate Finance Committee have demonstrated their interest in guaranteeing quality patient care to Medicare beneficiaries by establishing the Professional Standards Review Organization and Utilization Review procedures. In past Congressional testimony, the AAMC has spoken out against proposals which would be detrimental to the Medicare recipient. We will continue to do so and urge that the Subcommittee not lose sight of this important objective.

We assume the purpose of S. 3205 is to stimulate efficient and effective programs while ensuring high quality patient care. Critical comments made in this testimony support those purposes and are submitted with the intention of strengthening the legislation. We also realize that some of the problems inherent in the proposal are not due to a lack of will by the Subcommittee staff but reflect the infant "state of the art" in several areas.

The Association wishes to address one fundamental consideration concerning this legislation's principal philosophical and systematic approach. Underlying the proposed provider reimbursement reforms is an approach that recognizes the need for management flexibility. Retaining the freedom to organize and finance individual services within expenditure or cost limits is required for the hospital to continue to meet the needs of the population it supports. Reimbursement methods in S. 3205 for determining the hospital's routine operating cost essentially retain management's operational authority and flexibility. Other sections of the proposed bill -- overhead cost controls and contract approvals, for example -- eliminate the manager's prerogative. As elaborated upon later in this testimony, the AAMC would encourage the Subcommittee to avoid implementation of a system so restrictive that its administrative burden possibly outweighs its value.

Administrative Reforms

Establishment of Health Care Financing Administration

This Section proposes a centralization of the Federal health care financing function and a unification of administrative entities presently known as the Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance, Office of Nursing Home Affairs, and related research and statistical units. The Association supports efforts toward centralization and unification of Federal health care financing. Costs of hospitals which result from diffuse and conflicting administrative and reporting requirements and which add overhead

to the provision of direct patient services should be somewhat moderated by the policy of unification and administrative standardization which should accompany this reorganzation.

The present bill provides for an Assistant Secretary of Health Care Financing to direct the Health Care Financing Administration. The Assistant Secretary would report directly to the Secretary of Health, Education and Welfare. Establishing the position of Assistant Secretary for Health Care Financing seems to contradict the present bill's emphasis on centralization and consolidation, for the new Assistant Secretary for Health Care Financing would be at the same organizational level as the Assistant Secretary for Health. At a minimum, the presence of two Assistant Secretaries will require lengthened bureaucratic procedures for mutual coordination. And, in all likelihood, the presence of two Assistant Secretaries with major health care responsibilities will result in problems of coordination and conflict which could reduce the benefits of centralization. To further the goal of a unified and coordinated Federal health care policy, the Association recommends that the Health Care Financing Administration be under the direction of a Deputy Assistant Secretary of Health for Health Care Financing who reports to the Assistant Secretary for Health. The Assistant Secretary for Health would then be the Department's central individual for all health matters.

Consolidation of Federal health care financing responsibilities will contribute to reducing administrative confusion presently

faced by health care providers. If a Deputy Assistant Secretary for Health Care Financing is established to direct the unified agencies, gains of economy and efficiency will be preserved. While these would be valuable reforms, the Association believes the benefits of these reforms are limited by continuing the subordination of the health function within the Department of Health, Education and Welfare. A Cabinet-level Department of Health is needed to serve as the single point of responsibility for the nation's critically important health policies and programs. The Association hopes that the proposed consolidation is the first step in the movement toward the creation of such a Cabinet-level Department of Health.

State Medicaid Administration

The reform of state Medicaid administration to provide more rapid payment of health care providers is strongly endorsed by the Association. Because of delays in Medicaid payments to hospitals, health care providers in many states have had to borrow funds at substantial interest rates to provide adequate cash flow. These additional interest costs add to the nation's health care expenses without contributing to the direct provision of personal health services. Decreasing the time required for Medicaid payments should contribute, in at least a small way, to moderating the nation's health expenditures as well as to reducing the tension between hospitals and state governments.

Regulations of the Secretary

The Association understands and shares the general Congressional concern with present procedures for proposing, evaluating, and publishing Federal regulations. The provisions of Section 7, which would establish a 60 day comment period for regulations, are a much needed reform in this area. Sixty days will allow time for a more thorough evaluation and review. Moreover, it will enable individuals and groups to collect appropriate data to illustrate and substantiate their comments and to offer constructive suggestions. To help ensure that the Subcommittee's intentions are complied with, the Association recommends that some clarification or definition be provided in the Committee Report for the term "urgent" as it applies to the regulations. The Association would also like to emphasize that this reform should not be limited to Medicare and Medicaid programs alone. This Committee and others in both the House and the Senate are urged to consider the need for this reform and others in the area of administrative procedures for the publication of rules and regulations.

Provider Reimbursement Reforms

Uniform Accounts, Cost Reporting and Allocation Procedures

The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform cost reporting. A mechanism for assuring the comparability of financial data must be developed prior to

full implementation of the program. Experiences in such states as California and Maryland, where uniform financial reporting systems are being developed and implemented, demonstrate that, with the present state-of-the-art in this area, enormous efforts are required to attain the goal. Similarly, Federal efforts to develop uniform accounting and reporting programs, which are being developed as specified in Section 1533(d) of PL 93-641, provide evidence of the difficulties in this area. Therefore, the Association urges the Subcommittee to provide an adequate and phased-in period of implementation for uniform cost reporting subsequent to final passage of the legislation.

Classification of Hospitals

A fundamental concern of the Association is that the designation of specific hospital groups is fixed in the legislation. This eliminates much needed flexibility. Alterations based on experience will be most difficult to make on a timely basis. Recognizing that there is a lack of data available for analyzing the impact of this system, a more prudent approach would be to permit the agencies some flexibility with which to construct the system. It is important, however, that the Committee provide the Department with some specific guidelines and direction in which to proceed. Therefore, the Association recommends that S. 3205 state that hospitals "be classified by type and size" with some guidance in the Committee report, rather than stipulate the specific bed categories. It is further recommended

that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review progress, monitor implementation, examine problems encountered and make recommendations regarding appropriate solutions. The advisory board to be established should include representation from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector.

In the past, the Association has not specifically advocated a separate classification of teaching hospitals. Rather, if a cross-classification approach is to be used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion of such costs from routine operating costs in S. 3205 is a step in the proper direction.

The legislation does provide for the creation of a separate group of hospitals which are the "primary affiliates of accredited medical schools." It is difficult to evaluate the implications of creating such a group because of the absence of data. Efforts to gain data and experience with a separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be

excluded form the present scheme. Thus, there is uncertainty as to the relative merits of a separate group for teaching hospitals.

More importantly, the present legislation would restrict the "primary affiliates of accredited medical schools" to a single hospital per medical school. This is a gross injustice to many teaching hospitals. Limiting each medical school to one and only one "primary affiliate" is arbitrary and does not recognize the complexity or the reality of medical education in this nation. Therefore, the Association opposes the establishment of a specific classification for "primary affiliates of accredited medical schools" as proposed in S. 3205.

In the absence of adequate data and operational experience to evaluate the proposed classification scheme and to avoid arbitrarily limiting the "primary affiliates of accredited medical schools" to one hospital per school, the Association is of the opinion that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals." Instead of prescribing a pre-defined grouping for teaching hospitals, it is proposed that the Secretary be required to determine, in

consultation with the appropriate knowledgeable health organizations, a definition which most accurately reflects the teaching hospital's role as a referral center for tertiary patient care services and as an educational institution. This is a good example of an issue which would be brought before the above proposed Technical Advisory Board.

Determining Routine Operating Costs

The Association recommends that two additional components of routine operating costs be excluded. S. 3205 does propose removing "energy costs associated with heating or cooling the hospital plant." This is appropriate and desirable; however, it ignores the energy costs associated with lighting the hospital facility. Energy costs for lighting, like those for heating and cooling, are beyond the hospital's control. Therefore, the Association requests that energy costs for lighting also be excluded from routine operating costs. Secondly, since there is wide regional and institutional variation in malpractice premium rates, and because these rates are largely beyond the control of the hospital, malpractice insurance premiums should be added to the list of exclusions from routine operating costs which are contained in the proposal. It has been our understanding that there was every intention of excluding malpractice premiums, although the proposed statute has omitted it. The exclusion of energy costs for lighting and malpractice insurance premiums will help to ensure the remaining costs are comparable between facilities.

In determing routine operating cost, the proposed legislation includes a provision allowing for initial consideration of hospital wage levels, if available, for the local or state area where they are higher than the general wage levels in the area. Following this initial first year adjustment, future hospital increases would be controlled by increases for all wages in the area in which the hospital is located. An approach similar to this has been supported by the Association and would serve to address one of its major concerns.

A further consideration in the wage level methodology, however, relates to the particular nature of the tertiary care/ teaching hospital staffing patterns. The type and array of skilled personnel utilized in academic medical centers is frequently drawn from a national labor pool. For example, the University of Virginia Medical Center in Charlottesville is located in a rural area of the state and outside of an SMSA. It must, however, compete with medical centers in Richmond, Virginia, Washington, D.C., and Baltimore, Maryland for skilled personnel. Because many medical centers must recruit personnel outside of the immediate area and across state lines, the Association recommends that the legislation include a provision which recognizes the skilled labor requirements of large academic medical centers.

Section 223 of PL 93-603 permitted a provider, with appropriate public notice as determined by the Secretary to charge the patient for "...services which are more expensive than the items or services determined to be necessary in the efficient delivery

of needed health services..." S. 3205 in replacing Section 223 does not contain this or a similar provision. Providing that consumers and medical practitioners are appropriately appraised of additional charges prior to the use of services, the Association recommends that hospitals be permitted to charge the patient above the established cost ceiling (1) for medically necessary services which are more expensive than the items or services determined to be necessary in the efficient delivery of services and (2) for more expensive services directly requested or authorized by the patient.

S. 3205 will allow those institutions with routine operating costs below the ceiling for their group to share in the "surplus". One concern we must raise is the manner in which hospitals will be required to handle this "surplus". Although the Association believes it may very well be inappropriate to stipulate in legislation the specific ways this must be utilized, Congress is encouraged to provide some guidance while assuring that the institutions have flexibility in determining institutional priorities.

The Association strongly supports the case mix provision provided in S. 3205. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends this legislation include provisions for an exception and appeals process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

Section 10(e) provides that "nothing in this section shall be construed as otherwise limiting the authority of the Secretary to continue otherwise authorized efforts toward development of improved systems of reimbursement..." The Association recommends that this subsection be modified to strongly and positively encourage the Secretary to continue and, where appropriate, expand efforts to develop improved systems of reimbursement.

Assuring Medicare beneficiaries needed health care services and encouraging efficiency in the provision of health care should be the guiding principals of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case-mix differences found between hospitals. When this is done, illegitimate costs arising from inefficiency or extravagence can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospitals' ability to provide needed health services will be reduced.

In this regard, one has to be impressed with the thought and effort that went into the provider reimbursement portion of this proposal. One is also impressed with the real complexity of implementing the proposal on a national scale. While the Association finds the proposal, with suggested amendments, worthy of support, the Association recommends that we move forward cautiously and under the review and supervision of the above recommended Technical Advisory Board.

Practioner Reimbursement Reforms

The apparent purpose of Section 22(c) is to eliminate Medicare and Medicaid recognition of renumeration arrangements between physicians and hospitals in which the physician's fee-based income rate in his service practice is used as a basis for computing his compensation for Part A reimbursable services. In place of such arrangements, the subsection proposes recognition of "... an amount equal to the salary which would have reasonably been paid for such services..."

While this objective seems clear in principle, it is clouded with ambiguities in practical application. The bill includes no indication of the basis on which "...an amount equal to the salary which would have reasonably been paid..." is to be determined. Certainly the Association realizes and appreciates the desire of the Congress to permit those developing regulations to have some flexibility in implementing this amendment; however, in recruiting and negotiating with the medical staff, the hospital chief executive officer and/or medical school dean must be able to determine the amount of compensation that Medicare and Medicaid will recognize. Therefore, the Association requests that Congress either modify the proposed amendment to incorporate some specific guidelines for regulations or so specify its intent in hearings and Congressional Reports that those preparing the regulations have a clear and consistent direction for determining a reasonable salary for physicians in employment situations.

Miscellaneous Reforms

Percentage Contracts

Section 40, as the Association understands it, is designed, in part, to eliminate as reasonable charges Medicare and Medicaid recognition of expenses for services or facilities which are determined as a percentage of health service revenues. However, our discussions with many groups of individuals have indicated that there are varying interpretations for this subsection. Therefore, the Association requests that the Subcommittee clearly state the objective of this subsection in its report on this legislation.

Overhead Cost Controls

Section 40 will require the Secretary to establish regulations for determining the reasonable cost or charges of direct and indirect overhead expenses. This approach of regulating individual line-item expense components is one means of controlling costs; however, it seems to be in direct conflict with the philosophy and purpose underlying the cost ceilings imposed in Section 10. The direct and indirect overhead expense controls specified in this subsection are based on a system of itemizing and controlling individual, rather than aggregate, expenses. The Association believes that simultaneous controls on individual overhead expenses and aggregate cost ceilings places management in an untenable position. To provide efficient and effective services within the cost ceilings, the hospital director needs the administrative flexibility which the overhead controls would diminish. In its consideration of changes, the Association strongly recommends that the Subcommittee adopt exclusively a cost control philosophy of cost ceilings rather than a philosophy of both ceiling and line-item controls.

Contract Approval

This provision directs the Secretary to establish a program for review and advance approval of "consulting, management, and service contracts" with an annual cost of $10,000 or more. The Association strongly recommends that this subsection either be eliminated or significantly modified by the Committee. First, as with the overhead controls program, this contract approval amendment is an individual service control rather than an aggregate

ceiling control. Once again, the hospital director must try to live within a ceiling at the same time his operational flexibility to do so is reduced. Second, by requiring advance approval of virtually all types of hospital contracts, this amendment shifts operational management authority from the hospital director to the HEW staff. The hospital director and governing board could propose and implement but not decide on courses of action. In effect, DHEW will be managing by contract review significant aspects of the nation's hospitals. Third, by requiring all contracts with an annual payment of $10,000 or more to be approved, the amendment guarantees that DHEW will have to undertake a significant bureaucratic expansion. This $10,000 threshold is so low that the number of contracts requiring approval will be significant. Bureaucracy will mushroom and the resultant costs will be an additional burden on the nation's health expenditures. Fourth, the legislation requires a procedure to determine if the services may appropriately be furnished by contract. Even if government authorities could judge the reasonableness of a contract price and could evaluate the contractor's likely ability to perform the services, the governing board of the institution should retain the right to determine whether it wants a function performed by "in-house" or contract personnel.

The Association understands that this segment of the proposed Section 40 is intended to ensure that Medicare and Medicaid do not subsidize contracts of questionable value or contracts undertaken

with nearly fradulent intentions. These objectives are commendable. The provisions do not discriminate, however, between those contracts likely to be undersirable and those which are characteristic of routine hospital operations. It is an attempt to control the small percentage of irregularities by controlling everything. The Association recommends that this section be completely re-written to direct the Secretary to control only those irregular, nearly fradulent and self-dealing contracts which may be sources of abuse.

Conclusion

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 3205. The Association shares the Committee's objective of improving the Medicare and Medicaid programs, and the Association has offered this testimony on the legislation as a sincere effort to refine and improve the proposed amendments.

ACCREDITATION: PUBLIC POLICY NEXUS

Marjorie P. Wilson, M.D.*

HISTORY

The AAMC, first organized in 1876 and reorganized 1890, published its first list of member schools in 1896 and began inspection of the member schools in 1903. From the outset, membership in AAMC was based on compliance with established medical school standards. The organization adopted a resolution in 1876 which stipulated opposition to issuing diplomas without the graduate's name. Also, at that time a minimum standard for the medical course was established to consist of three courses of lectures, at least twenty weeks each. In 1877, the requirement that the medical course be three years in length was introduced. The latter requirement resulted in the dissolution of the original organization because so few medical schools were able to conform to the three-year standard, however, by 1890 there were sufficient numbers to reorganize.

During the late nineteenth century, there were virtually no legal restrictions to the establishment of medical schools and a variety of them developed, including those established primarily for the financial gain of the promoters and faculty, including "diploma mills" which sold diplomas with no pretense of providing medical training of any kind. As late as 1900 less than 10 percent of the practicing physicians were graduates of university-based medical schools, and only about 20 percent had ever attended lectures in medical schools. The majority were products of apprenticeships, and brief encounters with proprietary schools. Continuous concern by several organizations, including the AAMC and the American Medical Association, led to a few significant improvements toward the end of the century, such as specification of the content of the curriculum, the length of instruction and requirements for admission.

The first call for the organizational meeting of the American Medical Association in 1847 began with the statement: "It is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States." One of the first steps taken at the organizational meeting was the appointment of a committee on medical education which in 1904 was organized into the Council on Medical Education and Hospitals. The Council began inspecting medical schools in 1906, and until 1942 took independent action on the schools.

An outline of the history of the AAMC and AMA involvement in accreditation and the formation and activities of the LCME is attached as Appendix I. Early in this century the AMA took the initiative in encouraging the Carnegie Foundation for the Advancement of Teaching to sponsor a study of America's approach to medical education. Abraham Flexner was commissioned in 1908 to undertake a thorough study of the approximate 150 schools in existence at that time. The Flexner Report, published in 1910, was comprehensive and far-reaching and results were achieved promptly. The findings and recommendations

* Director, Department of Institutional Development, Association of American Medical Colleges (AAMC)

focused on three concerns: (1) the urgent requirement of overall raising of standards in admissions and instructions, (2) the importance of relating medical education to the universities and placing it under their jurisdiction as a discipline controlled and correlated with the liberal arts and sciences, and (3) the need to provide full-time staff and facilities that would combine instruction and research in a setting that would offer experience in the laboratory and hospital as well as the lecture hall. The result of these efforts was primarily the elimination of weak proprietary schools which could not meet the requirements of new state laws and the merger or affiliation of other schools into stronger, single institutions. By 1927 there were only 80 schools of medicine in existence as compared to approximately 150 in existence in 1905.

During the period of 1934-1939 a representative from the Council on Medical Education and Hospitals of the AMA and a representative of the AAMC separately visited each medical school in the United States and Canada -- a total of 89 schools. On the basis of these visits, a profile of each teaching program was prepared and the strengths and weaknesses of each component of the program were reported to the parent organizations. Accrediting decisions, however, continued to be made separately by each organization in an uncoordinated fashion. The undesirable aspects of this disparity led to closer ties of these two organizations, and in 1942, the Liaison Committee on Medical Education and Hospitals was formed to develop a cooperative effort, concerted action, policy coordination, and combined site visits to the schools of medicine. Since that time, the combined efforts of these two national agencies has provided the continuing assurance that the interests of students, the profession, the academic institutions and society in the maintenance of sound medical education programs are protected by enforcing adherence to acceptable standards of quality.

PURPOSE OF ACCREDITATION

The official policy statement of the LCME, Functions and Structure of a Medical School, advises that the information contained therein is, "intended... to assist in attainment of standards of education that can provide assurance to society and to the medical profession that graduates are competent to meet society's expectations; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated.

"The concepts expressed here will serve as general but not specific criteria in the medical school accreditation process. However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education."

The accreditation process provides for the medical schools a periodic, external review of assistance to their own efforts in maintaining the quality of their educational programs. Outside survey teams are able to focus on the areas of concern which are apparent, recommend other areas requiring increased attention, and indicate areas of strengths as well as weaknesses. In the recent

period of major enrollment expansion, the LCME has pointed out to certain schools that the limitation of their resources preclude expanding the enrollment without endangering the quality of the educational program. In yet other cases, it has encouraged schools to make more extensive use of their resources to expand their enrollments to meet public need. During the decade of the 60's particularly, the LCME encouraged and assisted in the development of new medical schools; on the other hand, it has cautioned against the admission of students before adequate and competent faculty is recruited, and the curriculum is sufficiently planned and developed and resources gathered for its implementation.

Since 1963 accreditation or reasonable assurance of accreditation has been a statutory prerequisite to eligibility for federal assistance for capital and later in 1965 for operating expenses.

Accreditation is related indirectly or directly with state licensing of physicians to practice. Twenty-five states require graduation from a program approved by the state licensing board, of these four permit explicit reliance on professional standards or lists prepared by national accrediting agencies. Four states require program approval by a state agency or official other than the licensing board and one state requires program approval by both the Board and the State Health Department. Ten require graduation from an approved program; of these only three make reference to accreditation; these specify approval based on educational standards required by a national professional accrediting agency; the seven remaining states leave the "approving" agency unspecified and in practice this is probably assumed by the licensing boards. The ten remaining states make specific mention of either the AAMC or the AMA in various combinations of one or the other, both, the licensing board and one or the other, or both, and the licensing board or both. Thus, there is no mention of the LCME as such, but seven make reference to it indirectly when specifying the national standards or national accrediting agency. Ten additional states specify the AMA and the AAMC with varying levels of delegated responsibility. Alaska is unique in specifying the "requirements of the Association of American Medical Colleges" as the standard.

Other aspects of the medical practice are based upon the accreditation by the LCME. For example, in order for a U.S. or Canadian medical school graduate to be eligible for entrance into an AMA approved hospital internship or residency, the applicant must have graduated from an accredited medical school. The only exception to this is the student who enters by the way of the so called "Fifth Pathway" which has been instituted in recent years.

THE PROCESS OF ACCREDITATION

The LCME membership includes six members appointed by the AAMC and six members appointed by the AMA, two public members selected by the LCME from nominations made by the parent organizations, and one federal liaison representative. These members represent a wide range of expertise within the medical profession, including educators and academicians, private practitioners of medicine, and hospital administrators as well as representatives of the public

sector and government. Over forty professionals plus the public members of the LCME, a student who is a member of the Executive Council of the AAMC, and a resident who is a member of the Council on Medical Education of the AMA, individually review and comment on the survey reports prepared for the LCME. These comments are recorded by the LCME Secretary and are presented as advice to the LCME when accreditation action is taken at its next scheduled meeting. The comments of each LCME voting member are also among those officially recorded. At each meeting there is discussion of the survey report and the recorded comments before final action is decided. Discussion is also elicited during the parent Council meetings at which time the actions of the LCME are subject to ratification.

In 1969 a formal system was established for rotating the Secretariat and Chairmanship of the LCME. This rotation system allows for a six-month overlap of the Secretariat and Chairmanship between the two parent organizations. This system permits one Secretary to arrange the schedule and carry out other logistics of the accrediting process for the total academic year. Full communication with the other organization's counterpart is consistently maintained on almost a day-to-day basis.

There are no honoraria or payments made to survey members by either the school, the accrediting agency or the parent organizations. An honorarium is offered to the team secretary if it is necessary to engage a non-staff member as secretary. A survey team generally consists of four members: a chairman, a secretary, and two members. The selection of the four team members is shared equally by the AMA and AAMC and there is a concerted effort to balance the teams from the standpoint of expertise and to avoid conflict of interest because of geographical location, previous institutional association and other similar considerations. It should be noted that no team member separately represents the AMA or the AAMC, but all represent the Liaison Committee on Medical Education. Finally, in a letter sent to the dean informing him of the survey team members, he is asked if the overall composition or any of the individual members present any significant conflict to the medical school, and if so, he is asked to so inform the LCME Secretary so that a change can be made.

In most cases, a full-time staff member of either the AMA or the AAMC serves as secretary of the survey team and takes responsibility for the completion of the survey report, although the determination of the opinions and judgments contained in the report and the recommendations is shared by the full team and there is ample opportunity for review of the report by the team before submission to the LCME. Further, there is opportunity for review of the report for the corrections of possible error of fact by the dean before the report is finalized. In addition, a verbal report of the team's findings is given at the conclusion of the visit, first to the dean, and then to the dean and president of the university. It is important to understand, however, that the survey team's recommendations are to the LCME and that the LCME has the prerogative of final action. Only rarely does the LCME make significant substantive changes in the survey reports, but on occasion it has required that they be rewritten and they have been returned to the team for this purpose.

The LCME does frequently shorten the period of time for which accreditation has been recommended or may impose a requirement for interim progress reports or staff visits. Also, in almost every instance, either the secretary, the chairman, or a team member, who made the site visit is present at the time the recommendations are discussed by the LCME. Appendix II summarizes LCME actions of recent years. Over the past five years, 47 schools have gained the full seven-year accreditation.

The Liaison Committee has also been concerned with the development of two-year schools of the basic medical sciences. A recent policy document, Special Criteria for Programs in the Basic Medical Sciences, categories the types of basic medical science programs that it will consider for accreditation as follows:

"1. Existing two-year programs accredited or provisionally accredited,

2. New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium, and

3. New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case, the program will be accredited as a component of the M.D. degree-granting institution or institutions.

"It is the policy of the Liaison Committee to discourage the establishment of programs in the basic medical sciences for medical students that do not have a clearly defined pathway leading to the M.D. degree. Recognizing the need for mobilizing additional university resources for the benefit of medical education, the Committee may approve a basic medical science program through the M.D. degree-granting school with which it is affiliated. In this case the program will be surveyed initially upon request and subsequently as part of the regular review process of the affiliated medical school."

The LCME is recognized officially in the federal sector by the Office of Education, as the organization responsible for accreditation of undergraduate medical education programs. In the private sector, the LCME was recognized first by the National Commission for Accreditation which through a recent merger with FRACHE has become the Council on Postsecondary Accreditation (COPA). In requesting recognition by OE, the LCME must show in great detail how it functions, including its scope, how it is organized and administered and what its procedures are. Further, the LCME must demonstrate its responsibility, its reliability, and that it is autonomous. The criteria by which the Office of Education, DHEW, judges an accrediting agency on these four points are given in detail in Appendix III.

Annually, since 1901, the JAMA has published the "Education Number" which lists all the approved schools of medicine, schools of basic medical sciences, and developing medical schools. The AAMC published its first list of cooperating schools in 1896; this list included 55 of the approximate 150 schools in existence then. The list of accredited schools is now found also in the AAMC Directory which first appeared in 1952 and is published annually. Prior to that time, a list of member schools was published in the annual proceedings which was publicly available. Other sources publicly reporting the activities of the LCME are found in the AAMC Weekly Activities Report and the AAMC Annual Report. Actions of the LCME are made public, although the survey reports prepared on behalf of the LCME are considered to be privileged and can be made public only by the institution about which the report is made and to which it is officially transmitted. The reports are sent to the president of the institution with copies to the dean and to the Chairman of the Board of Trustees.

ACCREDITATION - HASSLE OR OPPORTUNITY?

Having described accreditation thus far as an element of the social structure concerned with maintaining a minimal standard of quality, let us consider the opportunities that the accreditation process provides for going beyond a minimal standard. Observation of the accreditation process and participation in some thirty-five to fifty reviews per annum over the past five years, leads to the observation that perhaps the developing schools profit most from the accreditation process. They are examined at frequent intervals, usually annually, and the LCME has become more and more explicit in its criticism of faculty competence and experience in the generation and transmission of knowledge, curriculum development, and criteria for admission of students. On the other hand, some of the established schools, graduating large numbers of students who invariably pursue a successful career in medicine, view accreditation as a periodic and necessary evil and treat it in a perfunctory way, except on occasion to express outrage that the visitors may not be as distinguished as the faculty which they are evaluating.

A few institutions have recognized the accreditation survey as an opportunity for a comprehensive program or departmental review of the entire institution and have employed it as an instrument for encouraging change and self-renewal. Academic institutions are notoriously slow to change and this is probably good in the long run. They set the standards in many areas important to the quality of life, and we look to this set of institutions as the critics of our social structure. However, change they will, and change they do, more often these days at the whim of external forces. It is not easy to keep ahead of the external forces for change. Nor, is it easy to initiate a major process of self-examination and evaluation within a complex organization. But, if medical schools are to have a hand in shaping their own future, they must know where their strengths lie, where their problems exist or will develop, and must have data which describes the present state of things. They must have thought through plans for how to deal with problems, set goals, assess limitations, and plan for the future. As Robert Kirkwood has said, "Accreditation in the finest sense is not an end but a means to an end."[1]

A serious self-study by an institution, soundly planned and seriously executed, can become a powerful instrument for planning, evaluation and instituting necessary change throughout the organization. Institutions which expend their energies in concealing their problems until the accreditation team leaves are primarily wasting their own time and foregoing an opportunity for growth. The survey team does not come in the spirit of an examiner issuing a report card, but a group of colleagues or peers dedicated to serving the public good in helping the institution reach for the highest level of performance of which it is capable. The obligation of the survey team is to judge whether the institution has met a minimum standard. Its intention and approach are to be constructively helpful to the institution and to render the opinion of an objective outside group that has some basis of comparison with national standards. The institution which does not view the accreditation process as an opportunity which it can use creatively in its own interest cheats itself, hardly the survey team. William Kells has said, "Thanks to an increasing focus on institutional self-study and analysis of the outcomes of the educational process, accreditation at its best is quite effective. At its worst, it is a complete waste of time, a frantic jumping through hoops by institutions that have collected useless data."[2] Kells believes that institutional accreditation has two purposes: the first, to provide a means for members of the higher educational community to hold an institution accountable to its own stated objectives, and the second and most important is to improve educational processes and institutions. In the same article, he quotes Wendall Smith who said in response to a faculty member's initial disinterest, "Our accreditation may not be in question, but our future is."

If the institution has made its objectives clear and is able to demonstrate the extent to which it is meeting those objectives based on good evaluation procedures and output measures, it has no problem with accreditation. In this context, marked educational innovations can pass muster as easily as more traditional forms, since the object is the assessment of the clarity and merit of the objectives and the degree to which the institution has met its own stated objectives.

Beginning with the 1976-1977 academic session, the LCME will institute an organized institutional self-study system of accreditation of medical schools. This new approach to the periodic scrutiny of medical schools will call for increased faculty-student-administration involvement in identifying the strengths and weaknesses of its programs and the resources available in preparation for the visit by the survey team of the LCME. The staff of the LCME is prepared to work with each institution to be visited as the dean and faculty design their own analysis of institutional activities.

It is difficult, if not impossible, to evaluate the undergraduate medical education program without making a judgment about the nature of the graduate medical education program. As solutions are sought for improvements in the process for objective evaluation of graduate and continuing medical education programs, perhaps the self-study approach lends itself to a more comprehensive institutional view of accreditation of the continuum of medical education.

CRITICISMS OF ACCREDITATION

The controversial Newman report, which was concerned primarily with innovation in higher education, highlighted what I believe to be the principal differences of opinion about accreditation among our own constituency. Newman said, "In the name of protecting the standards of education, regional and specialized accrediting organizations pressure new institutions to develop faculty, building and educational requirements on the pattern of established conventional colleges and universities. Moreover, these organizations -- dominated by the guilds of each discipline -- determine the eligibility of these new institutions for public support. We believe that 1) the composition of established accrediting organizations should be changed to include representatives of the public interest; and 2) federal and state government should reduce their reliance on these established organizations for determining eligibility for federal support."[3] A principal criticism of accreditation is, and we know it has been said of the LCME, that the standards are too rigid, the view is too conventional and encourages educational programs which are not responsive to the public need, nor to the need of the students. On the other hand, the LCME receives an equivalent, if not greater amount, of criticism from its parent associations and their Councils that the standards are not strict enough and are not applied vigorously enough. There is continuing expression that the quality of medical education is deteriorating and that the LCME needs some stiffening where its spine is located.

Recently, there appears to be a creeping conviction among some of our constituents that enrollment in American medical education has been expanded sufficiently to meet the needs of our nation for physicians and that the LCME should "stop allowing new medical schools to start." Irrespective of the merits of such opinions, the LCME cannot become involved in any broad question of restriction of the supply of health manpower if it is to maintain its well-practiced posture of impartial, fair consideration of the adequacy of the resources available for development of a new program in medical education presented by any university which applies for the preliminary stage of accreditation.

Until the last decade, accreditation was a voluntary process carried out exclusively in the private sector. Because of the GI Bill following World War II, the Office of Education Accreditation and Institutional Eligibility Staff (AIES, OE) was established to review and certify educational institutions as appropriate sites of training for veterans receiving educational benefits. Since then, the federal government has come to rely on the decisions of private accrediting agencies to establish the eligibility of institutions for an increasing number of federal programs for the support of postsecondary education. Accrediting agencies were not initially established to perform this function. Their basic function was to raise standards of the education offered in the institutions which they accredit. In the field of medical education, by virtue of fact that federal legislation since the mid 60's has mandated accreditation of an institution to establish its eligibility first for federal construction funds, and later operating funds, the Liaison Committee on Medical Education has, in a sense, become a quasi-governmental agency. With the last renewal of the federal Manpower Legislation, the LCME was required to provide advice to the Secretary, DHEW, as to whether enrollment increases for "bonus classes" would jeopardize the accreditation of the institution before the Secretary granted the additional funds.

In recent years, comfortable with its growing reliance on private accreditation, the federal government has moved to place accrediting agencies in the position of enforcing certain public policies. The Office of Education has attempted to force the accrediting body to enforce civil rights legislation in the area of discriminatory practices and has said that a criterion for recognition by OE must be the enforcement of ethical practices in hiring, admissions, etc. The position of the Liaison Committee is that no matter how laudable the social policy, it is inappropriate for the LCME to become an agency of enforcement of federal statutes and should concern itself only with the judgment of the quality of the education program and consider other matters only as they impinge upon and influence the quality of the educational program. It is only in this context, then, that the Liaison Committee believes that it can concern itself with the ethical practices of an organization which it is evaluating.

While some express concern that the net effect of accreditation in medicine has been a force for homogenizing institutions and particularly newer institutions and has precluded promising new ventures and departures from traditional practice, so far the LCME has avoided litigation. But as it continues to have to deny accreditation and thereby eligibility for funding, it becomes progressively more vulnerable. It is more than ever essential that its criteria and standards be clear, be applied with consistency, and that its decisions and actions be carefully thought through and documented. This is only fair practice in anyone's view, but it challenges the resources of the staff and the committee members alike. No one associated with the process can be too conscientious. Objectivity, integrity and fair play must be at a conscious level as the work of the committee is pursued.

Sensitive to the need for scrupulous observance of due process, the LCME developed an appeals process which was formally approved in June, 1973. The process provides, in the case of an adverse action, for the appointment of a formal subcommittee of the LCME to review the action. Representatives of the school have an opportunity to appear before the subcommittee to present material and information germane to the review. The subcommittee then returns the case to the LCME with the summation of the matters considered and the evidence presented. If the LCME sustains its adverse action, then the school may appeal the action prior to public disclosure. The appeal is then heard by an Appeals Board appointed for the purpose of hearing the appeal. Such Boards are appointed from an Appeals Panel composed of persons judged to be qualified by training experience and reputation to make a fair and reasoned recommendation regarding the merits of an accreditation decision, and who have no present connection with the LCME or its parent Councils. In each case requiring such action, a three-member Appeals Board is appointed from the panel as follows: one named by the Chairman, LCME, one named by the institution appealing the action, and the third member chosen by the first two named.

At the present time the U.S. Commissioner of Education's authority to recognize accrediting agencies derives from Congress' exercise of the spending power; it has delegated to the Commissioner the authority to determine the eligibility of institutions under federal aid programs for postsecondary

education. The "recognition" of accrediting agencies is not a direct exercise of regulatory power, but rather a function which exists due to and only in the context of federal funds expenditure, otherwise there is no need for the federal government recognition of accrediting agencies. Only those agencies in fields for which the federal government has spending power need to seek official ederal recognition of their accrediting functions. Furthermore, an accrediting agency needs to be recognized only if it wishes the federal government to rely on its judgment in the process of expending federal funds, or if this has been mandated by federal statutes as is the case with certain funds relating to undergraduate medical education.

The recent report on "Respective Roles of the Federal Governmnet and State Governments and Private Accrediting Agencies in the Governance of Postsecondary Education" by William A. Kaplin points out that any federal involvement in private accreditation or other aspects of postsecondary education deeper than that authorized by the spending power would have to be justified under one of Congress' regulatory powers. The only such power with major pertinence to his report is the "Commerce Power" which authorizes Congress (and administrators to whom Congress delegates power) to regulate activities which are in or which affect interstate commerce. A more detailed reference on this matter appears in Appendix IV. Kaplin goes on to point out, however, that the spending power remains for now and for the immediate future as the primary legal path for federal involvement in postsecondary education.[4]

In a recent development, however, the Federal Trade Commission announced an investigation into whether the AMA may have "illegally restrained the supply of physicians and health-care services." According to reports, the thrust of the investigation by FTC will focus on three AMA activities: "its accreditation of medical schools and graduate programs; its definition of fields of practice for physicians and allied health personnel; and the limitations the AMA places on forms of health-care delivery inconsistent with the fee for service approach."[5]

OTHER PUBLIC POLICY ISSUES

The Equal Employment Opportunity Council (EEOC) an outgrowth of civil rights legislation of the mid-1960's is proposing to extend the applicability of its Uniform Guidelines on Employee Selection Procedures and through them its oversight from industry to the professions, including medicine. This is to be accomplished by extending the reach of the guidelines to licensing and certification boards and accrediting associations.

The guidelines apply to selection procedures which are used as a basis for any employment decision, which includes, but is not limited to any decision to hire, transfer, promote, demote, job or work assignments, membership (for example in labor organization) training, referral, retention, licensing and certification. It is not clear how accreditation directly affects any such decision, but the guidelines specifically state that they apply to accrediting associations.

The use of any selection procedure which is a standardized, formal, scored or qualified measure or combination of measures and which has an adverse impact on the members of any racial, ethnic or sex group with respect to any employment or membership opportunity will be considered to be discriminatory and inconsistent with the guidelines, unless the procedure is both validated and shown to be practically useful in accordance with the principles contained in the guidelines. An adverse impact on any racial, ethnic or sex group is demonstrated where the pass rate or selection rate is less than 80 percent of any other group. Each user of such a procedure is required to have available for inspection records or other information which will disclose the impact which its procedures have on opportunities of persons by identifiable racial, ethnic or sex groups in order to determine compliance.

It is clear that this is directly relevant to licensure, certification, and testing related to admission to medical school. It is not clear how this proposal relates to accreditation although the proposed EEOC Guidelines (which have the force of regulations once promulgated in the FEDERAL REGISTER) put the accreditation agencies on notice that they do. In addition to any presumed direct applicability of accreditation to employment decisions, it is assumed that the expectation of EEOC would be that accrediting agencies would withdraw accreditation from institutions which were presumed to employ discriminatory practices. Needless to say, the LCME is concerned with the concept proposed by EEOC as it affects the admissions process and that they may extend it to many other aspects of undergraudate medical education.

Another example of interest by a federal agency can be cited by the inquiry of the General Accounting Office last year. GAO undertook a general review of the accrediting process, including the organizational structure, operating procedures and actions of nationally recognized accrediting agencies and associations. The LCME responded to the inquiry, but we were not able to learn the purpose of the review nor the outcome.

Finally, recent state legislation of interest is the enactment or proposal of the so-called "Sunshine Laws" notably in Florida and California. While state statutes vary in detail, they would essentially require that a survey team visiting the medical school hold open public hearings on site; and, the LCME would be required to open all its accreditation records to public inspection, and open its deliberative proceedings to the public.

The concern is that these measures would inhibit frank, substantive discussion of findings and the necessary candid exchange of views in arriving at final judgments and in the transmission of constructive advice to the institutions. On the other hand, a criticism of accreditation from the public's standpoint is that while "all schools are accredited", there are not distinctions which are made public among the institutions on the matter of educational quality. Parents and students alike would like to know which are the "best medical schools"; but whose view of "best." The LCME and its parent associations assiduously avoid ranking of medical schools for any purpose.

In spite of continued efforts toward improvements, the accreditation process is an imperfect instrument. Nonetheless, it remains a principal instrument developed by the institutions and the profession as a means of monitoring and assessing institutional or program quality. The primary responsibility for assuring that educational programs are of acceptable quality rests with each institution. It is a responsibility borne primarily by its faculty exercising its collective academic judgment in the design and implementation of the curriculum, the assignment of competent educators, the selection of capable students and the evaluation of their performance. The institution is assisted in gauging its own performance through the availability of external assessment procedures and instruments. The accreditation process is a major instrument for such evaluation. It is also a major safeguard against encroachment by outside agents that desire to influence educational policy such as admissions standards or curriculum content. Recent examples of this kind of intrusion include two state legislatures which attempted to establish admissions criteria.

The support and assistance of the concerned institutions in improving and refining the process of accreditation is needed and actively sought. It is equally important to join in defending the integrity of voluntary accreditation from encroachment and dismantlement by federal authority and over-zealous critics of the system.

QUOTED BIBLIOGRAPHY

[1]Kirkwood, Robert, "The Myths of Accreditation", Educational Record, Vol. 54, No. 3 (Summer Issue), 1973, pp. 211-215.

[2]Kells, Herbert R., "Institutional Accreditation: New Forms of Self-Study", Educational Record, Vol. 53, No. 2 (Spring Issue), 1972, pp. 143-148.

[3]Report on Higher Education, March 1, 1971, Frank Newman, Stanford University, Chairman of Task Force, p.66.

[4]Kaplin, William A., "Prespective Roles of Federal Government, State Governments, and Private Accrediting Agencies in the Governance of Post-secondary Education", The Council on Postsecondary Accreditation, 1975, pp. 10-12.

[5]"AMA Role in Supply of Doctors, Services Set for FTC Study", Wall Street Journal, April 14, 1976.

HISTORY OF AMA AND AAMC INVOLVEMENT IN ACCREDITATION AND THE FORMATION AND ACTIVITIES OF THE LIAISON COMMITTEE ON MEDICAL EDUCATION

Precursor - Establishing minumum standards

1876 - organization of AAMC - 22 medical colleges
Resolutions and proposals
Opposed to issuing diplomas without the graduate's name
Medical course to consist of three courses of lectures, at least 20 weeks each

1877 - 15 medical colleges
All colleges extend annual term to six months, medical course to be three years in length

1882 - 11 medical colleges
Break up of Association because too many schools could not conform to the three year rule

---

1890 - 66 medical colleges - meeting called to discuss:

1. Three year course of six months each
2. Graded curriculum
3. Written and oral examinations for graduation
4. Laboratory instruction: chemistry, histology, pathology
5. Examination in English for admission

1905 - Requirements for AAMC membership:

1. High school diploma or equivalent for admission
2. Examinations before graduation
3. Adherence to a standard curriculum, four years in length, 4,000 hours

1905 AAMC standards adopted by National Confederation of State Medical and Licensing Boards.

1903 - AAMC began inspections of member schools

1904 - AMA Council on Medical Education and Hospitals established.

1907 - First AMA classification of ABC schools

1908 - AAMC published schedule of minimal equipment every "high grade" medical school should have Adopted by Confederation of State Boards

1910 - Flexner Survey commissioned by AMA: found that 35 of 50 member schools not meeting AAMC minimal standards

"Essentials of an Acceptable Medical School" approved by AMA House of Delegates

1913 - First joint action by AAMC and AMA
One year of college, required, admission to medical year

"Essentials" revised

1914 - First school dropped by AAMC for not conforming to minimal standards - five others warned

1916 - AAMC-AMA Two years of college for medical school admission

1918 - AAMC-AMA list of accredited medical colleges accepted Federation of State Medical Boards

1919 - AAMC-AMA first joint inspection of medical schools

1925 - AAMC-Commission on Medical Education

1927 - "Essentials" revised

1932 - Publication report Commission on Medical Education: Willard Rappleye

1933 - "Essentials" revised

1934 - "Essentials" revised.

1936 - "Essentials" revised.

1938 - "Essentials" revised.

1942 - AAMC-AMA - Liaison Committee on Medical Education established.

1945 - "Essentials" revised.

1951 - "Essentials" revised.

1952 - AAMC-published objectives of undergraduate medi- education - incorporated in AAMC-AMA statement of "Essentials of Acceptable Medical Schools both two and four year programs

1957 - Revision of "Functions and Structures of a Modern Medical School by AMA House of Delegates and AAMC Assembly.

1958 - Adoption of "Functions and Structures of a School of Basic Medical Sciences" by the AMA House of Delegates and the AAMC Assembly.

Development of joint AMA-AAMC questionnaires under the sponsorship of the LCME.

1963 - Adoption of the final report of the LCME Committee on Accreditation Procedures

Federal Statute PL88 - 129
Requires accreditation by agency recognized by Commissioner of Education as a condition of eligibility for Federal grants under new programs.

1969 - Enlargement of the LCME to include a Federal and public representative

Participation of New York State Representatives on site visits to schools in New York State.

1970 - Adoption of Proposal for the Expansion of the Membership and Function of the LCME by the LCME, AMA-CME, and AAMC Executive Council.

1972 - Adoption of "Functions and Structure of a Medical School" by the AAMC Assembly.

1973 - Adoption of "Functions and Structure of a Medical School" by the AMA House of Delegates.

Adoption of "Special Criteria for Programs in the Basic Medical Sciences" by the AAMC Assembly and the AMA House of Delegates.

SUMMARY OF LCME DECISIONS ON ACCREDITATION IN USA
1957 - 1974

	Total Actions	No. Actions other than LRA or Prov. Approval	Maximum Term of Full Approval		Time Limited Full Approval Years					Probation (Confidential prior to 1968)	Provisional Approval	LRA
			No.	%	5	4	3	2	1			
1957 - 58	11	9	3	33%			3	2		1	2	
1958 - 59	11	11	8	73%		1			1	1		
1959 - 60	13	12	9	75%	1		2				1	
1960 - 61	14	13	9	69%			1	2		1	1	
1961 - 62	17	15	10	67%			1			4	2	
1962 - 63	17	14	9	64%	1		1		1	2	2	1
1963 - 64	13	12	9	75%			3				1	
1964 - 65	20	11	5	45%	1	1	1	1		2	2	7
1965 - 66	12	12	5	41%	2	2				3		
1966 - 67	16	13	8	61%		1	1			3	2	1
1967 - 68	14	11	11	100%						confidential	3	
										open		
1968 - 69	26	21	15	71%			4	1		1	3	2
1969 - 70	30	24	15	62%	1	2	1	4	1		1	5
1970 - 71	36	24	16	66%	1		2	5			10	2
1971 - 72	21	15	5	33%	2		3	4		1	5	1
1972 - 73	31	20	10	50%	2	1	4	2		1	11	
1973 - 74	25	19	5	26%		5	1	6	2		4	2
1974 - 75	32	29	11	38%	2	5	2	7	1	1	2	1

11/20/75

JRS/ke

Excerpt from: Nationally Recognized Accrediting Agencies and Associations

Criteria and Procedures for Listing by the U.S. Commissioner of Education and Current List, August 1974, by The Accreditation and Institutional Eligibility Staff, U.S. Department of Health, Education, and Welfare, Office of Education, Bureau of Post-secondary Education, pages 7-9.

§ 149.6 Criteria.

In requesting designation by the U.S. Commissioner of Education as a nationally recognized accrediting agency or association, an accrediting agency or association must show:

(a) Functional aspects. Its functional aspects will be demonstrated by:

(1) Its scope of operations:

(i) The agency or association is national or regional in its scope of operations.

(ii) The agency or association clearly defines in its charter, by-laws or accrediting standards the scope of its activities, including the geographical area and the types and levels of institutions or programs covered.

(2) Its organization:

(i) The agency or association has the administrative personnel and procedures to carry out its operations in a timely and effective manner.

(ii) The agency or association defines its fiscal needs, manages its expenditures, and has adequate financial resources to carry out its operations, as shown by an externally audited financial statement.

(iii) The agency's or association's fees, if any, for the accreditation process do not exceed the reasonable cost of sustaining and improving the process.

(iv) The agency or association uses competent and knowledgeable persons, qualified by experience and training, and selects such persons in accordance with nondiscriminatory practices: (A) to participate on visiting evaluation teams; (B) to engage in consultative services for the evaluation and accredition process; and (C) to serve on policy and decision-making bodies.

(v) The agency or association includes on each visiting evaluation team at least one person who is not a member of its policy or decision-making body or its administrative staff.

(3) Its procedures:

(i) The agency or association maintains clear definitions of each level of accreditation status and has clearly written procedures for granting, denying, reaffirming, revoking, and reinstating such accredited statuses.

(ii) The agency or association, if it has developed a preaccreditation status, provides for the application of criteria and procedures that are related in an appropriate manner to those employed for accreditation.

(iii) The agency or association requires, as an integral part of its accrediting process, institutional or program self-analysis and an on-site review by a visiting team.

(A) The self-analysis shall be a qualitative assessment of the strengths and limitations of the institution or program, including the achievement of institutional or program objectives, and should involve a representative portion of the institution's administrative staff, teaching faculty, students, governing body, and other appropriate constituencies.

(B) The agency or association provides written and consultative guidance to the institution or program and to the visiting team.

(b) Responsibility. Its responsibility will be demonstrated by the way in which —

(1) Its accreditation in the field in which it operates serves clearly identified needs, as follows:

(i) The agency's or association's accreditation program takes into account the rights, responsibilities, and interests of students, the general public, the academic, professional, or occupational fields involved, and institutions.

(ii) The agency's or association's purposes and objectives are clearly defined in its charter, by-laws, or accrediting standards.

(2) It is responsive to the public interest, in that:

(i) The agency or association includes representatives of the public in its policy and decision-making bodies, or in an advisory or consultative capacity that assures attention by the policy and decision-making bodies.

(ii) The agency or association publishes or otherwise makes publicly available:

(A) The standards by which institutions or programs are evaluated;

(B) The procedures utilized in arriving at decisions regarding the accreditation status of an institution or program;

(C) The current accreditation status of institutions or programs and the date of the next currently scheduled review or reconsideration of accreditation;

(D) The names and affiliations of members of its policy and decision-making bodies, and the name(s) of its principal administrative personnel;

(E) A description of the ownership, control and type of legal organization of the agency or association.

(iii) The agency or association provides advance notice of proposed or revised standards to all persons, institutions, and organizations significantly affected by its accrediting process, and provides such persons, institutions and organizations adequate opportunity to comment on such standards prior to their adoption.

(iv) The agency or association has written procedures for the review of complaints pertaining to institutional or program quality, as these relate to the agency's standards, and demonstrates that such procedures are adequate to provide timely treatment of such complaints in a manner that is fair and equitable to the complainant and to the institution or program.

(3) It assures due process in its accrediting procedures, as demonstrated in part by:

(i) Affording initial evaluation of the institutions or programs only when the chief executive officer of the institution applies for accreditation of the institution or any of its programs;

(ii) Providing for adequate discussion during an on-site visit between the visiting team and the faculty, administrative staff, students, and other appropriate persons;

(iii) Furnishing, as a result of an evaluation visit, a written report to the institution or program commenting on areas of strengths, areas needing improvement and, when appropriate, suggesting means of improvement and including specific areas, if any, where the institution or program may not be in compliance with the agency's standards;

(iv) Providing the chief executive officer of the institution or program with an opportunity to comment upon the written report and to file supplemental materials pertinent to the facts and conclusions in the written report of the visiting team before the accrediting agency or association takes action on the report;

(v) Evaluating, when appropriate, the report of the visiting team, preferably the chairman;

(vi) Providing for the withdrawal of accreditation only for cause, after review, or when the institution or program does not permit reevaluation, after due notice;

(vii) Providing the chief executive officer of the institution with a specific statement of reasons for any adverse accrediting action, and notice of the right to appeal such action;

(viii) Establishing and implementing published rules of procedure regarding appeals which will provide for:

(A) No change in the accreditation status of the institution or program pending disposition of an appeal;

(B) Right to a hearing before the appeal body;

(C) Supplying the chief executive officer of the institution with a written decision of the appeal body, including a statement of specifics.

(4) It has demonstrated capability and willingness to foster ethical practices among the institutions or programs which it accredits, including equitable student tuition refunds and nondiscriminatory practices in admissions and employment.

(5) It maintains a program of evaluation of its educational standards designed to assess their validity and reliability.

(6) It secures sufficient qualitative information regarding the institution or program which shows an on-going program evaluation of outputs consistent with the educational goals of the institution or program.

(7) It encourages experimental and innovative programs to the extent that these are conceived and implemented in a manner which ensures the quality and integrity of the institution or program.

(8) It accredits only those institutions or programs which meet its published standards, and demonstrates that its standards, policies, and procedures are fairly applied and that its evaluations are conducted and decisions rendered under conditions that assure an impartial and objective judgment.

(9) It reevaluates at reasonable intervals institutions or programs which it has accredited.

(10) It requires that any reference to its accreditation of accredited institutions and programs clearly specifies the areas and levels for which accreditation has been received.

(c) Reliability. Its reliability is demonstrated by —

(1) Acceptance throughout the United States of its policies, evaluation methods, and decisions by educators, educational institutions, licensing bodies, practitioners, and employers;

(2) Regular review of its standards, policies and procedures, in order that the evaluative process shall support constructive analysis, emphasize factors of critical importance, and reflect the educational and training needs of the student;

(3) Not less than two years' experience as an accrediting agency or association;

(4) Reflection in the compoisition of its policy and decisionmaking bodies of the community of interests directly affected by the scope of its accreditation.

(d) Autonomous. Its autonomy is demonstrated by evidence that —

(1) It performs no function that would be inconsistent with the formation of an independent judgment of the quality of an educational program or institution;

(2) It provides in its operating procedures against conflict of interest in the rendering of its judgments and decisions.

(20 U.S.C. 1141(a))

Excerpt from: "Respective Roles of Federal Government, State Governments, and Private Accrediting Agencies in The Governance of Postsecondary Education", William A. Kaplin, The Council on Postsecondary Accreditation, 1975, p. 11.

Courts have held that this power justifies establishment of federal wage and hour standards for employment in public and private higher educational institutions engaged in commerce (Maryland v. Wirtz, 392 U.S. 183 (1968)) and federal regulation of labor-management relations in private institutions of higher education (e.g., Cornell University, 183 NLRB No. 41, 74 LRRM 1269 (1970)). This power is also the legal basis for Federal Trade Commission jurisdiction over proprietary schools which "commit unfair or deceptive acts or practices in Commerce" (15 U.S.C. §345(a)) and would permit extension of similar jurisdiction to non-profit postsecondary institutions. Any future application of antitrust laws to postsecondary educational institutions or accrediting associations would also be based on the commerce power.[11/]

---

11. See generally, regarding postsecondary education and the antitrust laws, Wang, "The Unbundling of Higher Education," 1975 Duke L.J. 53. And for a recent Supreme Court decision rejecting the existence of a "learned professions exemption" under which accrediting agencies have sometimes claimed immunity from antitrust laws, see Goldfarb v. Virginia State Bar, 43 U.S. Law Week 4723 (1975).