

*Miss Liblemeyer*



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**ADMINISTRATIVE BOARD  
THURSDAY, JANUARY 19, 1978  
9 a.m.-1 p.m.  
ADAMS ROOM  
WASHINGTON HILTON HOTEL**

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COUNCIL OF DEANS  
ADMINISTRATIVE BOARD  
January 19, 1978  
9 a.m. - 1 p.m.  
Adams Room  
Washington Hilton Hotel

AGENDA

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I. Call to Order	
II. Chairman's Report	
III. Action Items	
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B. Executive Council Actions --	
1. Approval of Subscriber (Executive Council Agenda)....	(25)
2. Student Representation on the LCME (Executive Council Agenda).....	(29)
3. OSR Resolution on Graduate Medical Education Directory (Executive Council Agenda).....	(30)
4. Committee on Future Staffing of LCGME and CCME (Executive Council Agenda).....	(32)
5. Report of the Committee on Physician Distribution (Executive Council Agenda).....	(35)
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7. Cost Containment Program of the National Steering Committee on Voluntary Cost Containment (Executive Council Agenda).....	(62)
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B.	Recommendations of the AMA Commission on the Cost of Medical Care (Executive Council Agenda).....	(79)
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ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

September 15, 1977  
9 a.m. - 1 p.m.  
Kalorama Room  
Washington Hilton Hotel

DRAFT

PRESENT

(Board Members)

Steven C. Beering, M.D.  
Christopher C. Fordham III, M.D.  
Neal L. Gault, Jr., M.D.  
Julius R. Krevans, M.D.  
William H. Luginbuhl, M.D.  
Clayton Rich, M.D.  
Robert L. Van Citters, M.D.

(Guests)

Ivan L. Bennett, Jr., M.D.  
George Lythcott, M.D.  
Robert G. Petersdorf, M.D.  
Thomas A. Rado, M.D., Ph.D.  
Paul Scoles

(Staff)

Robert J. Boerner  
John A. D. Cooper, M.D., Ph.D.  
Juel Hodge  
Thomas J. Kennedy, Jr., M.D.  
Joseph A. Keyes  
Diane Newman  
Jaimee S. Parks  
Dario O. Prieto  
James R. Schofield, M.D.  
Marjorie P. Wilson, M.D.

I. Call to Order

The meeting was called to order at 9:00 a.m. by Julius R. Krevans, M.D.,  
Chairman.

II. Chairman's Report

Dr. Krevans reported that he had spend a delightful summer in Maine  
and had lost his razor.

III. Minutes of the Previous Meeting

The minutes of the June 23, 1977 meeting of the Administrative Board  
were approved as distributed.

IV. Executive Council Actions

A. Health Manpower Legislation

Dr. Bennett and Dr. Cooper reported to the Administrative Board that Congressman Rogers and Senator Kennedy had both become convinced that the USFMS provision of the Health Manpower Act needed modification. There had been extensive negotiations over the past month and a half between the staffs of the Senate and House Committees. The AAMC leadership had been called upon for extensive consultation in this process. On September 14, the day prior to this meeting, a proposal had been agreed upon. Since the Congress was scheduled to adjourn no later than October 16 and had an already crowded calendar, the time for continued negotiation had ended. Dr. Bennett stressed that rapid action was required if there was to be any hope to modify the existing legislation. The parties in both houses considered AAMC support and public approval of their action essential if this new legislative initiative was to succeed.

The proposal which had been agreed to but which had not yet been reduced to writing consisted of the following elements. The USFMS provision would be eliminated. It would be replaced by a requirement that each school as a condition of eligibility for capitation, increase its third year class by the number of students equal to 5% of its first year class. There would be no academic standing or residency restrictions on the schools' ability to select such students for transfer. Students could be placed in either the second or third year class at the discretion of the school. The pool would consist of U.S. students at foreign medical schools who had passed Part I of the National Board and U.S. students at two-year U.S. medical schools. The pool was estimated to consist of between 1,000 and 1,200 individuals. Since 5% of the first year class consisted of 781 students, something like 3/4 of the students eligible under the current legislation would be accommodated under this new program. There would be restrictions on the ability of medical schools to recruit from other health professions schools to preclude this legislation as being an incentive for raiding these schools. The clear objective of the Congress was to accommodate a large portion of the U.S. foreign medical students who would be guaranteed places under the current legislation. Consequently, while the legislation would probably not specifically outlaw the matriculation of Ph.D.s, the clear intent of the Congressional committees was to discourage such practice. The only transfers from medical schools which would serve to meet this requirement would be transfers from two-year programs. Again, this was to prohibit raiding as a means of complying with the requirement.

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The only substantial difference between the House and the Senate versions of this proposal at the current time was its duration. The Senate had in mind a one-year provision and the House a two-year provision.

Dr. Luginbuhl questioned whether the proposal contemplated a requirement that the third year class be 5% greater than the entering first year class or whether it would require the addition to the first year class of a number of students equal to 5% of the first year class. He pointed out that this made a substantial difference in that the first alternative would require that all attrition be made up and that this in effect would, in many cases, double the number of students which had to be taken since attrition was equal to approximately 5% of the class. Since the language had not been reduced to writing, no definitive answer to this question could be given. However, it was pointed out that the Congressional objective was to accommodate approximately 3/4 of the eligible students and that this objective would be met by the second alternative.

The proposal would require that schools participate in capitation in the first year in order to be eligible for participation in later years of the program. Finally, the proposal would permit waivers: 1) where there were inadequate clinical facilities, 2) where accreditation would be jeopardized by such an expansion and 3) in the case of new schools which were continuing to expand their enrollments.

The House committee had contemplated changing the requirement for primary care residencies, but in light of the short time remaining in this legislative session, decided to carry this over into the following session of Congress. The House version of this bill might, however, contain provisions modifying the Guaranteed Student Loan Program.

Drs. Cooper and Bennett emphasized that the Congressional staff members had been most cooperative in the effort to achieve an appropriate modification to this legislation. No further modification of the proposal was considered possible and both sides of the Hill considered support from the U.S. schools as an essential element in moving the legislation forward. Thus, it appeared that the alternatives available to the AAMC were to support the new proposal actively, or to stand the substantial risk that the present legislation would remain in effect.

The Board members expressed their judgment that this proposal was a vast improvement from the current statute and consequently

deserved the support of the AAMC governance. In particular, it would permit the medical faculties to exercise their judgment in admissions determinations. The one thing that this proposal would not do is provide credit to those schools which had made a good faith effort in accepting eligible U.S. foreign medical students during the 1977-78 academic year. In many ways, this was quite regrettable, since the AAMC leadership had made a substantial push to encourage schools to take this course of action and had relied upon assurances that such action would not work to the schools' detriment. It was pointed out, however, that the use of the first year class as the base upon which the percentage increase would be required, would at least not penalize those institutions which had made such an effort.

Action:

On motion, seconded and approved without dissent, the Administrative Board voted to recommend that the Executive Council support this legislative initiative and commend the Association Chairman and President for their efforts in achieving this favorable result.

B. Recognition of the Liaison Committee on Medical Education by the U.S. Commissioner of Education

The U.S. Office of Education considered the petition of the Liaison Committee on Medical Education for recognition by the Commissioner on March 25, 1977. The decision of the Commissioner was to continue the recognition of the Liaison Committee for two years with an interim report due in one year, addressing the concerns identified in the USOE staff analysis and endorsed by the Commissioner's Advisory Committee. Some of these concerns are procedural matters within the purview of the LCME. Others are more fundamental and related to the structure and the relationships between the AAMC, the AMA and the LCME.

Dr. Beerling, Alternate Chairman of the Liaison Committee on Medical Education, referred to the extensive material in the Executive Council agenda detailing the background and current status of the LCME recognition by the Office of Education. He informed the Administrative Board of the action of the Council on Medical Education of the AMA which was substantially the same as he proposed for AAMC adoption. He moved that the Board recommend that the Executive Council:

1. Authorize the LCME to exercise final authority with respect to determining the accreditation status of schools of medicine including decisions regarding probation and disaccreditation.

2. Authorize the LCME to exercise final authority to adopt its own operating policies and procedures.
3. Reserve to itself and the AMA Council on Medical Education authority to exercise final approval of the educational standards upon which accreditation decisions are made.
4. Authorize the LCME to review its anticipated operating expenses annually and present a proposed budget for adoption by the AMA Council on Medical Education and the AAMC Executive Council.
5. Seek continuing discussions among the sponsoring members of the Coordinating Council on Medical Education directed at clarifying the relationship between that body and the LCME.
6. Authorizing the LCME to establish formal criteria for the appointment of its members.

Dr. Luginbuhl questioned the effect of such an action on the licensing requirements. In response, it was pointed out that no other changes in the LCME process were currently contemplated. That is, that the current procedure for prior review of the site visit reports and subsequent endorsement of the LCME actions by the Executive Council and the CME would be continued. Such endorsement by the two parent bodies should serve to fulfill the licensure requirements of the states.

Action:

The motion, as presented, was seconded and approved by the Administrative Board.

Dr. Rado requested that the Board consider suggesting that the LCME be requested to expand its membership to include student representation. Dr. Beering responded that this matter would be on the agenda of the Task Force on Accreditation Policy of the LCME at its next meeting. What the OSR leadership desired, however, was that the LCME receive an expression of the AAMC sentiments on the matter. Dr. Luginbuhl moved that the Administrative Board go on record as favoring student participation on the LCME. This motion was seconded and approved.

C. Removal of Schools from the Status of Probationary Accreditation

The Liaison Committee on Medical Education initiated action to remove Texas Tech University School of Medicine and the University of Missouri-Kansas City School of Medicine from the status of probationary accreditation and to restore full accreditation.

Action:

The Administrative Board recommended that the Executive Council approve the removal of these schools from probation.

D. Election of Provisional Institutional Member

Northeastern Ohio Universities College of Medicine received provisional accreditation by the Liaison Committee on Medical Education and requested Provisional Institutional Membership in the AAMC.

Action:

The Administrative Board recommended that subject to ratification by the full Council of Deans, the Executive Council recommend that Northeastern Ohio Universities College of Medicine be elected to Provisional Institutional Membership in the AAMC by the Assembly.

E. Election of Distinguished Service Member

A committee consisting of Drs. Luginbuhl and Van Citters reviewed recommended nominees for Distinguished Service Membership received from the Council membership. Dr. Andrew D. Hunt was nominated by the committee.

Action:

The Board recommended that the Executive Council nominate Andrew D. Hunt, M.D., for election as a Distinguished Service Member the the Assembly, contingent upon ratification by the full Council of Deans.

F. Approval of Subscribers

The following schools requested Subscriber status and meet the criteria established by the Executive Council:

Universidad Catolica De Puerto Rico  
Ponce, Puerto Rico

University of Texas System  
Austin, Texas

Action:

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

#### G. Statement on Withholding of Services by Physicians

Dr. Rich, Chairman of the committee appointed by Dr. Bennett to develop a statement for consideration by the Executive Council on this subject reported on the actions of that group. The Committee discussed the matter by telephone over the summer and met as a group on September 14 to formulate its recommendation. Two documents were presented to the committee for its consideration. The first developed by Dr. Rich gave the subject a fairly concise treatment and the second, developed by Dr. Jonsen, provided a more extended treatment and its efforts were focused on a detailed consideration of the more elaborate document. At the conclusion of its deliberations, all of the members of the committee present were able to support the extended statement as modified by the group. The resultant document was presented to the Administrative Board for its endorsement, consideration by the Executive Council, and ultimately adoption by the Assembly. Since the revisions had been made rather hurriedly, however, it was presented with the understanding that the committee would be permitted to make further refinements of a purely editorial nature.

Dr. Rich also reported that the committee took a second action which was to recommend that the Administrative Board of the Council of Deans consider an appropriate means to respond to the OSR concern for the need for a clarification of the role of students and student responsibility in instances where job actions occur in institutions where the students are receiving instruction. The committee felt that the issue was closely related to its charge but that it fell outside its specific mandate. Consequently, the committee did not deal with it directly, but concurred that it was an appropriate matter for the AAMC to take up.

The length of the document recommended by the committee created a problem for members of the Board. The question was raised whether the appropriate audiences would take the time to actually read the document. In response, it was pointed out that the issues involved are complex and that a shorter statement had difficulty addressing these issues adequately. Nevertheless, members of the Board felt that the length of the document undermined its utility and minimized its impact.

Consideration was given to the formulation and adoption of a shorter statement which would summarize the conclusions of the long document proposed by the committee. After substantial discussion devoted to formulating an appropriate short form, a motion to receive the committee's report as a background document and to adopt the short statement as

the AAMC position failed for lack of a second. It was pointed out that the arguments in support of the AAMC position were of more significance than the weight of the AAMC as an organization behind a position.

Additional questions were raised regarding the appropriateness of the AAMC entering this arena. Furthermore, it was pointed out that the timing of the statement would make it appear that its adoption was simply another method of attack on the issue of unionization of housestaff.

A motion to table consideration of the entire issue was seconded but failed on a divided vote.

In further deliberations, it was pointed out: 1) that the Administrative Board of the Council of Teaching Hospitals had substantial concerns about the appropriateness of an AAMC position on this matter and 2) that in large measure the statement was directed toward a group which was not represented in the governance of the AAMC; namely, the practicing physicians.

The Board concluded that the matter deserved more extended consideration and consequently was not ripe for bringing to the Assembly at the Annual Meeting this year.

Action:

On motion, seconded and carried, the Board deferred further consideration of this issue.

H. Establishment of a Cabinet Level Department of Health

At its May 19, 1972 meeting, the Executive Council established a position in support of a separate Department of Health. Similar actions have been taken by major health professions organizations.

In past sessions of Congress, Mr. Rogers has introduced a bill establishing a separate Department of Health. No Committee actions have been taken on his bill. Similar bills have been introduced this year by Senator Mathias (R-MD), Congressman Carter (R-KY), LeFante (D-NJ), and Murphy (D-NY).

The Carter Administration has recommended that, as a part of the reorganization of the Department of Health, Education and Welfare, a separate Department of Education be established. The major higher

education organizations are opposing a separate Department of Education believing that their interests will be lost because of the domination of the Department by primary and secondary educators. The Administration proposes to leave health and welfare in a single department.

Action:

The Board recommended that the Executive Council reaffirm its position that a separate Department of Health be created within the Executive Branch of the federal government.

- I. Proposed AAMC Testimony on the National Academy of Sciences' Report, "Health Care for American Veterans"

Action:

The Board recommended that the AAMC present testimony to the Veterans Committees of the House of Representatives and the Senate along the following lines:

1. Concur with NAS/NRC finding on the importance of affiliation agreements in improving the health care of the veteran.
2. Urge the extension, expansion and strengthening of affiliation agreements through, inter alia, more extensive sharing agreements and selective, discrete and sensitive implementation of the VA regionalization program.
3. Offer AAMC participation in a joint study of affiliation agreements for long term planning purposes.

V. Discussion Items

- A. Task Force on Minority Student Opportunities in Medicine Interim Report

Dr. George Lythcott, Chairman of the Task Force, joined with the Administrative Board and reviewed the deliberations and recommendations of the Task Force. The Interim Report appeared in the Executive Council agenda. Dr. Lythcott reviewed its contents and set out the planned future activities of the Task Force. These included: 1) visits by task force members to 14 medical schools; 2) study the development of self-instructional units in general chemistry,

college mathematics, college physics, and cellular-molecular biology; 3) identify predominantly black undergraduate institutions with sizable minority populations who have the potential to successfully increase the size of the minority applicant pool; 4) assess whether minority students apply to an appropriate selection and number of schools to maximize their chances of admission; 5) development of a model retention program for minority students.

The Administrative Board noted that Dr. Lythcott's verbal remarks modified the treatment of the Task Force concerns regarding the use of the new MCAT in the admissions process. The Task Force statement as revised is as follows:

"The Task Force addressed the use of the MCAT in the admissions process, and its impact on the selection of medical students. It recognizes that the old MCAT was designed only to predict success in the basic sciences, but that the New MCAT is designed also to relate to performance in clinical situations. The state of the art is such that significant effort and experience will be required before appropriate data can be developed to support the latter application. The Task Force is also aware that it is possible for test scores as with other quantified measures to assume undue weight in admissions decisions. Further it noted the importance of evaluating non-cognitive characteristics in these situations and that this is not the purview of the New MCAT. In recognition of these issues, the Task Force recommends that admissions committees exert caution to restrict the use of the New MCAT data to those applications for which supportive information is available. Further, it strongly supports the conduct of the necessary research and development projects both by the AAMC and its individual members to make possible the assessment of relevant non-cognitive characteristics as well as efforts to extend the value of the New MCAT as a predictive tool."

Dr. Fordham, a member of the Task Force, stated his concerns and that of the Task Force included three components:

- 1) that the new MCAT has no track record and thus is difficult to assess as an evaluation instrument;
- 2) that the new MCAT scores, when analyzed by white and minority status, fall into two bell-shaped curves displaying distinctly different levels of performance.

Consequently, the Task Force is concerned that inappropriately heavy reliance on the scores alone would tend to place the minority applicants at a substantial disadvantage.

- 3) The pendency of the Bakke case created substantial apprehension that schools may decide or be forced, to rely on quantitative data in undue measure as a means of making admissions decisions.

Dr. Cooper suggested that the Task Force may wish to make a positive statement relying on the Sedlacek studies to the effect that "it has been demonstrated that criteria other than test scores are important in evaluating the probable success of minority students in higher education". Dr. Cooper also pointed out the analysis of the comparison of the grade point averages, old and new MCAT results on the basis of minority and non-minority status displays almost precisely the same variation. This further demonstrates the inadequacy of the suggestion of the California Supreme Court that the objectives of minority admissions programs could be accomplished if they were based on income or economic disadvantage only.

Dr. Ivan Bennett suggested that the experience of his own institution had demonstrated the utility of the work/study program as a specific mechanism for familiarizing minority students with medicine, increasing their interest in entering the profession, and in preparing them for entering the course of studies.

Dr. Rado suggested that the Task Force may wish to give consideration to the desirability of recommending that the Guaranteed Student Loan Program contain interest subsidies for disadvantaged students.

The Board expressed its appreciation to Dr. Lythcott for appearing and discussing the Interim Report of the Task Force with them.

#### VI. Report of the OSR Chairperson

Dr. Thomas Rado, OSR Chairperson, gave a brief report on the deliberations the previous day of the OSR Administrative Board. Those discussions focused primarily on the statement on the withholding of services by physicians, the issue of student representation on the LCME and final program planning for the Annual Meeting.

#### VII. Adjournment

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

Tentative Program  
1/10/78

COUNCIL OF DEANS  
SPRING MEETING

April 24-27, 1978  
Snowbird, Utah

Monday, April 24

1:00 p.m. - 5:30 p.m.

Arrival & Registration

5:30 p.m. - 7:00 p.m.

Business Meeting

Report of the President

7:00 p.m. - 8:30 p.m.

Reception

Tuesday, April 25

8:30 a.m. -10:10 a.m.

SESSION I -- Moderator: Julius R. Krevans

"THE RELATIONSHIP BETWEEN FEDERAL & STATE POLICY"

8:30 a.m.

"The Context: A Review of the Forces at Play"

--Lewis Butler

Professor

Health Policy Unit

Univ. of Calif.-San Francisco

9:00 a.m.

"The Problem: A National Perspective"

--Margaret Costanza

Asst. to the President for  
Public Liaison

9:30 a.m. -10:10 a.m.

Discussion

10:10 a.m. -10:20 a.m.

Coffee

10:20 a.m. -12: Noon

SESSION II

"THE RELATIONSHIP BETWEEN FEDERAL & STATE POLICY"

10:20 a.m. -10:50 a.m.

"The Problem: The Articulation of Federal &  
State Policies"

--Peter Petkas

Director, Project Management &

President's Reorganization

Project

Tuesday, April 25 (cont.)

10:50 a.m. - 11:20 a.m.

"A Paradigm: The Implementation of the  
National Health Planning Act"

--Eugene Rubel  
Special Asst. to the  
Administrator  
Health Care Financing Admini-  
stration  
DHEW

11:20 a.m. - 12 Noon

Discussion

Noon - 6:00 p.m.

UNSCHEDULED

6:00 p.m. - 7:30 p.m.

SESSION III

"REPRISE & DISCUSSION"

6:00 p.m. - 6:30 p.m.

"An Association Perspective on National  
and State Policy Initiatives"

--David M. Kinzer  
President  
Massachusetts Hospital Assn.

Wednesday, April 26

"TOWARD MORE EFFECTIVE RELATIONSHIPS WITH STATE GOVERNMENT"

8:30 a.m. - 10:10 a.m.

SESSION IV -- Moderator: Christopher C. Fordham

"TWO VIEWS FROM THE STATE CAPITAL"

8:30 a.m. - 9:00 a.m.

"A Governor's View of Medical Education  
and Health Care"

--James B. Hunt, Jr.  
Governor of North Carolina

9:00 a.m. - 9:30 a.m.

"A Legislator's View of Medical  
Education and Health Care"

--John Milton  
former State Senator  
from Minnesota

9:30 a.m. - 10:10 a.m.

Discussion

10:10 a.m. - 10:20 a.m.

Coffee

Wednesday, April 26 (cont.)

10:20 a.m. - 12 Noon

SESSION V

"TWO APPROACHES"

10:20 a.m. - 10:50 a.m.

"The University of Washington Approach"

--John N. Lein  
Associate Dean  
Continuing Education &  
Development

10:50 a.m. - 11:20 a.m.

"The Independent Colleges and Universities  
of Missouri Approach"

--Charles Gallagher  
Executive Director  
Independent Colleges &  
Universities of Missouri

Robert Blackburn  
Director, Governmental Relations  
Washington University

11:20 a.m. - 12 Noon

Discussion

12 Noon - 6:00 p.m.

UNSCHEDULED

6:00 p.m. - 7:30 p.m.

SESSION VI-- Moderator; Stuart A. Bondurant

"REPRISE & DISCUSSION"

6:00 p.m. - 6:30 p.m.

"The Role of State Education Departments"

--

6:30 p.m. - 7:30 p.m.

Discussion

Thursday, April 27

8:30 a.m. - 12 Noon

Business Meeting of the Council of Deans

12 Noon

ADJOURNMENT

STATE GOVERNMENT  
ISSUE IDENTIFICATION SURVEY

I. Undergraduate Medical Education

A. Admissions

- 1) Admissions Quota Systems (Rural Applicants) (B & C)
- 2) Mandatory Acceptance of Students from Rural Areas (A)
- 3) Admissions of Out of State Students; Tuition for Out of State Students (B & C)
- 4) The Extent to Which the State Government May Influence the Admissions Policies of a Private Medical School by Means of a Yearly Appropriation (A, B, & C)
- 5) Admissions Lottery (B & C)

B. Curriculum

- 1) Promotion of Specific Courses to be Requirement of Curriculum (Medical Economics, Sociology) (A & B)
- 2) Gross Interference of Board of Medical Quality Assurance in Curriculum (or efforts to do so)
- 3) Legislation passed a Bill that Regulates the Curriculum in a Specific Topic Area (Human Sexuality). Similar Legislation may Follow in Others. (A & C)
- 4) Legislation Requiring Geriatric Training (B)
- 5) Legal incursions into curriculum content, i.e., human sexuality, nutrition. (A, B, & C)
- 6) Matching curricular objectives with licensure requirements (A)

C. Service Requirements for Graduates

- 1) Service requirements for graduates of state schools (B)
- 2) Mandatory service requirements for graduates of state schools (A)
- 3) Mandatory service in state by graduates (A & B)
- 4) Service requirements - graduates and housestaff (A, B, & C)
- 5) Obligated service requirements including anticipated "buy out" clauses. Potential conflicts with other sponsored scholarship programs. (B)

D. Proliferation of Schools

- 1) What is being done to control proliferation of both M.D.'s and medical schools? (A & B)
- 2) Expanding schools and/or new schools based on student interest, not need for M.D.'s
- 3) How should we educate the legislators concerning the adverse influence of additional medical schools? (B)
- 4) Biennial efforts to establish new medical schools (there are already 7 medical schools and 1 osteopathic school) (A & B)

E. Student Support

- 1) Financial support of students attending private schools (A)
- 2) State financing of medical students (A)

F. Fifth Pathway and USFMS Transfer

- 1) Mandated Fifth Pathway requirement (B)
- 2) Fifth Pathway (A, B, & C)
- 3) Mandated Fifth Pathway programs (C)
- 4) Funded, but not mandated, Fifth Pathway program. (A & B)
- 5) Fifth Pathway (C)
- 6) Future Course of Fifth Pathway Programs in relation to FMS transfer provisions of P.L. 94-484. (A, B, & C)
- 7) Mandated foreign transfer program on state basis in lieu of federal requirement for one year only (1978). (A & B)
- 8) How do we convince the legislators that their mandated Fifth Pathway program is not the best way to provide more good physicians for the state? (B)
- 9) Fifth Pathway expenses re products -- passing boards, specialty entered -- cost, etc. (B)
- (10) The responsibility of a private medical school in providing some clinical training to state residents attending overseas medical schools. (A, B, & C)

II. Financing Medical Education (UME)

A. Formula Budgeting

- 1) Legislative formulas for financing medical education (B)
- 2) New budgeting formula format calculating student contact hours, faculty contact hours -- ultimately arriving at "course cost". (A)
- 3) Level of state financial support to state schools. Faculty/Student ratio. (B)

B. State Subsidy of Private Schools

- 1) What are the "quid pro quos" asked by state governments for private medical school state capitation or subsidy. (B)
- 2) State funding at private medical schools (B)
- 3) Relationship with state government where services are offered by both public and private schools (B)
- 4) Re-accreditation of D.C. General Hospital (A & B)

C. Relationship of Federal Capitation to State Funding

- 1) Capitation -- Directory USFMS, etc., responses by states (A&B)
- 2) Capitation requirements -- what Congress proposes (A, B, & C)
- 3) Federal Capitation -- should it be continued? Other financial support alternatives. (A, B, & C)
- 4) Likelihood of continued federal capitation funding and possible alternatives thereto as a means of federal participation in medical school financing (A & C)

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D. Clinical Practice Plans, Reimbursement of Teaching Physicians

- 1) Clinical practice plans in strict full time arrangements (A, B, & C)
- 2) Faculty pay plans - independence from state (B & C)
- 3) Attorney-General and legislative interest in auxiliary corporations, practice plans, and auxiliary university enterprises. (A & B)
- 4) Reimbursement of teaching physicians. (A)
- 5) Collection of Medicare billings by school physicians -- 51% clause regarding private practice (B)
- 6) Reimbursement for service of hospital-based physicians, i.e., radiology, anesthesiology, pathology (A, B, & C)

E. General and Miscellaneous Concerns Re Financing Medical Education

- 1) Decreasing financial support (A&B)
- 2) What is state's obligation to aid financially in education of physicians and allied health professions? (A, B, & C)
- 3) State support of medical education, i.e., loan funds, mandated service requirement for repayment, research support, faculty enrichment. (A & B)
- 4) State support for medical education (B)
  - a) undergraduate
  - b) graduate
  - c) teaching hospital
- 5) Costs of health education in the total state educational budget (20-25% of state's higher education budget) (A, B, & C)
- 6) Assumption of financial obligations initiated by federal programs. (B & C)
- 7) State capital expenditures for medical science building construction. (B)
- 8) State appropriating overhead income -- as source of revenue. (B)
- 9) Operation of Medical College of unfunded or partially funded service programs, e.g., medical examiner system (B & C)
- (10) State support for biomedical research (B & C)
- (11) No increase in state support for six years.

III. Graduate Medical Education

A. Funding of Residency Positions

- 1) Funding postgraduate positions. (B)
- 2) "State" funding for residency positions (A & B)
- 3) Deduction of resident's "educational" component from reimbursement. (B & C)
- 4) Residency Review; #'s of positions; requirement that residents who have attended medical school in Wisconsin be selected (A & B)
- 5) Examination of efficacy of resource allocation to residency training rather than undergraduate medical education (A & B)
- 6) State funding of graduate medical education (family practice presently partially funded: primary care may be next). (A, B, & C)

B. Payment of Stipends

- 1) Housestaff stipends currently paid by community hospitals (and third party payers) (A)
- 2) Funding of stipends for physicians in Graduate Medical Education

C. Primary Care, Family Practice

- 1) State mandated requirements for primary care vs. specialty residencies. (B)
- 2) State support of both family practice residency training and primary care residency training. (B & C)
- 3) State support for primary care residency programs (the state has recently legislated support for new family practice residency programs). (A & B)
- 4) Support for primary medical care education (including urban and rural) (B & C)
- 5) Interest in primary care, family practice, and medical graduate retention in the state. (A, B, & C)
- 6) Mandated departments of family practice (B & C)
- 7) Need for primary care residencies (A & B)
- 8) Number and training of primary care physicians (B)
- 9) Primary care - family medicine (with 2 large private schools and 2 state schools in Missouri, where might we be pressed?) (A)
- (10) Future role of "family practice" as a academic discipline. (A, B, & C)
- (11) Ambulatory care training facilities. (C)

IV. Regionalization and Manpower Distribution

A. Regionalization of Medical Center Activity

- 1) Efforts to regionalize medical college and center activity (education, patient referral) (A, B, & C)
- 2) Involvement of medical schools in satellite educational or primary medical care centers outside their base community. (A, B, & C)
- 3) Area Health Education Programs (A, B, & C)
  - a) Interest of Pennsylvania in this program
  - b) Interaction with state health plan
  - c) How fits with HSA
- 4) Value of AHEC (A)
- 5) Outreach programs to aid distribution of physicians in state. What has been most effective at least cost? (A, B, & C)
- 6) Developments in Special population groups (aging, mental health services, etc.). (A, B, & C)
- 7) Statewide health education systems (A)

B. Manpower Distribution

- 1) Geographic distribution (A)
- 2) State review of health manpower distribution (A & B)
- 3) Cost/Benefit analysis: (in terms of M.D. retention and alleviation of maldistribution) of funding proposed expansion of class sizes of state's two medical schools (A & B)
- (C & B) 4) Supply of physicians to Washington, D.C. ghetto areas. (A & B)
- 5) Are provider states, e.g., Midwest, concerned with drain of federal service programs? (B)
- 6) State-supported programs to promote physician service in underserved areas. (B & C)
- (B) 7) Incentives for rural practice, health service corps programs, etc. (A & C)
- (B) 8) How can we influence thinking in the state legislature concerning the "need for a physician in every county and town"? Are medical schools responsible for physician distribution? (B)

V. Planning and Cost Control

A. Role of the HSA's

- 1) Health Service Agencies (A)
- 2) State review of bed allocation vis-a-vis HSA, etc. (A & B)
- (B) 3) Influence of HSA on school programs and grants -- both regional and state HSA (B)
- 4) The University teaching hospital and the:
  - a) HSA and SHCC
  - (C & B) b) VA
  - c) State welfare departments
  - d) State Dept. of Mental Health
- 5) Impact of HSA -- Review of certain manpower training programs (A, B, & C)
- 6) State coordinating council and local HSA impact (positive or negative) on capital expansion of clinical teaching facilities (B)
- 7) Role of HSA, State coordinating councils, etc. (A & B)
- (B & A) 8) Impact of HSA guidelines for health care delivery on health manpower production. (B)
- 9) Certificate of need legislation state and local health planning -- HSA's, etc. (A, B, & C)
- (10) Relations between HSA, local and state and medical schools (B)
- (11) State agencies determining programmatic priorities and certificates of need in teaching hospitals affiliated with the medical school. (B)
- (12) HSA review of student manpower training grants (A & B)
- (C & B) (13) HSA influence on medical schools in the future. What is federal and local jurisdiction? What does it all mean?
- (C & B) (14) Relationship with SCHE. Will they ever understand medical education?

B. Rate Regulation and Cost Control

- 1) Hospital rate regulation (A)
- 2) Rate setting and determination of need (B)
- 3) Rate review procedures in academic state medical centers (C)
- 4) Impact of state certificate of need on state educational programs. (A & B)
- 5) Inequitable grouping of hospitals for reimbursement. (B & C)
- 6) Examination of cost of Graduate medical education and the effect of hospital rate review controls on its continued support (A & B)
- 7) State and institutional responses to national cost containment initiatives -- what about public education? (B)
- 8) Federal efforts to control rising health care costs (Califano letter 12/2). Should such federal efforts be circumscribed? (A & B)
- 9) Medical care cost control and regulation. (A & B)

VI. Teaching Hospitals and Clinics

A. Funding

- 1) Funding of Teaching Hospitals (B)
- 2) Support of clinical teaching facilities (B)
- 3) State support to partially underwrite costs of primary teaching hospitals of medical schools (public and private) in the state. (A & B)
- 4) Funding of medical education in affiliated community hospitals (undergraduate and graduate) (A, B, & C)
- 5) Indigent care financing at University hospital, especially physician fee component (A, B, & C)
- 6) National Health Insurance as related for coverage for indigents (A)

B. Affiliation Relationships

- 1) State approval of medical school/hospital affiliations (A&B)
- 2) State academic medical center affiliation with other state owned hospitals. (B)
- 3) State regulation of the types and locations of affiliated residency programs. (A & B)

VII. Licensure and Certification of Physicians

- A. Licensure of physicians. Coordination of efforts of the several states and acceleration complete reciprocity. (B & C)
- B. Impaired physician rehabilitation; interaction with licensing board (B)
- C. Recertification of physician, i.e., state requirements (A, B, & C)
- D. Relicensure (A & B)

VIII. Unique and Significant Developments

- A. State Approval of All Federal or Sponsored Programs (A & B)
- B. State of California Board of Medical Quality Assurance is questioning whether authority for accreditation of medical schools can be delegated to LCME, especially if accreditation documents are confidential and not available to members of division of licensing. (B)
- C. Proposed bill to regulate DNA research.
- D. Professional liability for faculty. Advantages of excellent legislation originated by medical school. (C)

IX. Miscellaneous

- A. How does one avoid problems with his own university when involved in state politics? (B)
- B. Politics is no game for amateurs -- how does one become intelligently involved on an occasional basis? (B)
- C. Interstate-Interinstitutional, Intrastate-intrainstitutional comparison of costs of medical education -- bad data badly used (A, B, & C)
- D. Relationships with coordinating board for higher education. (B)
- E. Academic medical center faculty consultation and informational source to state legislators. (B & C)
- F. State correctional or penal system interaction with medical schools. (B)
- G. Academic program retrenchment in times of economic recession. (A, B, & C)
- H. Status of Special Programs in: (B)
  - 1. Alcoholism and Substance Abuse
  - 2. Aging
  - 3. Emergency Medicine

- I. Involvement of the medical school faculty (as "volunteers") in attempting to rectify profound administrative and professional problems in state institutions for chronic disease, mental retardation and psychiatric disorders. (A, B, & C)
- J. How should medical schools relate to continued attempts of certain groups (nurse practitioners, PAs, etc.) to acquire the capacity for independent relationship to patients? (B)
- K. No involvement of this state in medical education except through state university.