

*Miss Lilleneyn*



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**ADMINISTRATIVE BOARD  
THURSDAY, MARCH 23, 1978  
9 a.m.-1 p.m.  
CHEVY CHASE ROOM  
WASHINGTON HILTON HOTEL  
WASHINGTON, D.C.**

COUNCIL OF DEANS  
ADMINISTRATIVE BOARD  
March 23, 1978  
9 a.m. - 1 p.m.  
Chevy Chase Room  
Washington Hilton Hotel

AGENDA

Page

- I. Call to Order
- II. Executive Session
- III. Chairman's Report
- IV. Action Items
  - A. Approval of Minutes ----- 1
  - B. Executive Council Actions --
    - 1. Election of Provisional Institutional Members  
(Executive Council Agenda).....(22)
    - 2. HEW Handicapped Regulations and Medical School  
Admissions (Executive Council Agenda).....(24)
    - 3. AAHC Statement on Accreditation of Educational  
Programs in Allied Health (Executive Council  
Agenda).....(34)
    - 4. AAMC Recommendations on FY 79 Appropriations for VA  
Department of Medicine & Surgery Programs  
(Executive Council Agenda).....(49)
    - 5. Emergency Meeting on Medical Manpower Legislation  
(Executive Council Agenda).....(51)
    - 6. Withholding of Services by Physicians (Executive  
Council Agenda).....(53)
    - 7. AAMC Statement on Involvement with Foreign Medical  
Schools (Executive Council Agenda).....(57)

- 8. Industry-Sponsored Research and Consultation:  
Responsibilities of the Institution and the  
Individual (Executive Council Agenda).....(62)
- 9. AAMC Biomedical and Behavioral Research Policy  
(Executive Council Agenda).....(77)

V. Discussion Items

- A. Discharge in Bankruptcy of Student Loans (Executive  
Council Agenda).....(109)
- B. Workload Problems in the Division of Research Grants -----27  
of the National Institutes of Health -- Carl D. Douglas, Ph.D.  
Director  
Div. of Research Grants  
NIH
- C. Medical School Admissions Criteria -----33

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

Minutes

January 19, 1978  
9 a.m. - 1 p.m.  
Adams Room  
Washington Hilton Hotel

DRAFT

PRESENT

(Board Members)

Stuart A. Bondurant, M.D.  
John E. Chapman, M.D.  
Christopher C. Fordham III, M.D.  
Neal L. Gault, Jr., M.D.  
John A. Gronvall, M.D.  
Richard Janeway, M.D.  
Julius R. Krevans, M.D.  
Clayton Rich, M.D.  
Robert L. Van Citters, M.D.

(Staff)

Robert J. Boerner  
Judith B. Braslow  
John A. D. Cooper, M.D.  
Thomas J. Kennedy, M.D.  
Joseph A. Keyes  
Diane Newman  
Jaimee S. Parks  
James R. Schofield, M.D.  
John F. Sherman, M.D.  
Marjorie P. Wilson, M.D.

(Guests)

Robert G. Petersdorf, M.D.  
Paul Scoles  
Peter Shields

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 on the activities at the Annual Officers' Retreat, held December 14-16, 1977 and briefly reviewed the report of the session which was provided the Executive Council.

III. Minutes of the Previous Meeting

The minutes of the September 15, 1977 meeting of the Administrative Board were approved as submitted.

IV. Executive Council Actions

A. Approval of Subscribers

Action:

The Board recommended that the Executive Council approve East Tennessee State University College of Medicine for Subscriber status.

B. Student Representation on the LCME

At its October 19-20, 1977 meeting, the Liaison Committee on Medical Education voted to request that the AMA Council on Medical Education and the AAMC Executive Council each appoint a student to serve as a non-voting member of the LCME. The following criteria for the student appointees were established. The person must be:

- 1) An upperclassman who had commenced the clinical phase of study;
- 2) A student in good academic standing;
- 3) A student whose performance warranted the judgment that the responsibilities to the LCME would be capably executed;
- 4) A student whose academic standing will not be jeopardized by his or her responsibilities to the LCME.

Such appointments would be for a one-year period and would be subject to the concurrence of the LCME. A student, who on completion of an initial term on the LCME, had an academic year of studies remaining before graduation would be eligible for reappointment.

The parent bodies would assume the expenses of student attendance at LCME meetings through the regular LCME budgeting process.

Paul Scoles, OSR Chairperson, reported the discussion of this issue by the OSR Board. The Board expressed a desire to solicit as many sources as possible for candidates. It also suggested that the deans of the schools of the final choices be contacted to certify that they met the established criteria for selection.

Action:

The Board recommended that the Executive Council accept the invitation of the LCME to appoint a student as a non-voting observer participant in accordance with the conditions set out. The COD Administrative Board was generally supportive of the process suggested by the OSR Administrative Board.

C. OSR Resolution on Graduate Medical Education Directory

At the 1977 Annual Meeting the OSR adopted the following resolution which appeared on the Executive Council agenda for action.

WHEREAS, students' selection of internship/residency programs in the past has been primarily based on anecdotal information from peers, advisors, etc. rather than on accurate, objective information, and

WHEREAS, the NIRMP Directory is limited to a listing of available internship/residency programs, and

WHEREAS, there presently exists no formal mechanism whereby medical students may obtain information concerning the characteristics of residency programs in the U.S., and

WHEREAS, the AAMC is currently extending its interests and activities to graduate medical education,

BE IT RESOLVED, that we hereby direct the OSR Administrative Board to coordinate the formation of a booklet containing information gathered from residents and program directors of all U.S. post-graduate training programs. This information shall be obtained from questionnaires circulated annually in the final month of each training year to all first and second year residents and program directors. The content of these questionnaires shall be determined by a group designed by the OSR Administrative Board to include a majority of students, with appropriate input from other sources.

The content of the questionnaires should include items such as call schedule, average number of patients per resident, ancillary personnel, hours spent with attending physician per week, degree of independent thought encouraged (scale 0-6), degree of responsibility (scale 0-6), benefits (vacation time), and other items deemed necessary in order to provide a comprehensive description of each program. This booklet should be up-dated annually and circulated to all U.S. medical schools.

We furthermore direct the OSR Administrative Board to explore with NIRMP the expansion of the data in the NIRMP Directory to accomplish the goals of this resolution. The OSR Administrative Board may modify minor details in order to implement the spirit of the resolution.

-Approved by OSR at the 1977 Annual Meeting

Mr. Scoles relayed the request of the OSR Administrative Board that this motion be tabled.

Action:

The Board endorsed the OSR Board recommendation that the proposal for an extensive survey and the publication of a new Graduate Medical Education Directory be tabled.

D. Committee on Future Staffing of LCGME and CCME

The Committee on Future Staffing of the CCME defined five possible methods of staffing the CCME and/or its Liaison Committees. Recommendations of the Committee, which have been forwarded by the CCME to its parent organizations for consideration and comment, appear in the appendix of these minutes.

In previous discussion and action by the Executive Council, it was recommended that the LCGME should receive first priority for independent staffing. This position was reaffirmed by the Executive Council at its September 1977 meeting and by the Officers' Retreat in December.

Dr. Cooper discussed the financial implications of the move to independent staffing. The AMA would not continue to support 1/2 of the cost of the accreditation process off the top and in addition pick up a ratable portion of the remaining costs allocated on the basis of the number of seats held by each organization. The AAMC, the ABMS and the CMSS could not afford to pay an allocable portion of the current total budget devised by the AMA. He pointed out, however, that a substantial part of the total budget covered AMA overhead and that much of the remainder paid for AMA staff time. In neither case is it possible to have confidence that all of the charges are entirely warranted, (there is no AMA staff effort allocation study, for example) and it is believed that savings could be achieved through more effective and efficient use of staff time. Ultimately, the cost of GME accreditation will have to be borne by charges to the programs or institutions accredited. Costs could be reduced by lengthening the term of approval to 5 or even 10 years, and coordinating the review of many programs under the aegis of a single institution.

The Board concurred in the desirability of improving the quality of LCGME staffing.

Action:

The Board recommended that the Executive Council recommend independent staffing for the LCGME only (under option #4 of the report of the Committee on Future Staffing).

#### E. American College of Surgeons Letter

At its March 1977 meeting, the Executive Council considered a letter dated March 4, 1977 sent by the Board of Regents of the American College of Surgeons to the parent organizations of the Coordinating Council on Medical Education. This letter questioned the role of the Liaison Committee on Graduate Medical Education and the CCME in reviewing programs of graduate medical education. It challenged the authority of these organizations to oversee or approve actions of Residency Review Committees.

The Executive Council asked the Association to respond by stating forcefully its disagreement with the American College of Surgeons' view that RRCs should be independent of LCGME and CCME review and providing the three following principles on which to base the response:

1. The Association supports the ACS recommendation that there be a free-standing, independent staff for the LCGME and the Residency Review Committees, not related in any particular way to a single parent organization.
2. The LCGME serves and should continue to serve as the private sector accrediting agency for programs of graduate medical education. The RRCs should continue to review the on-site evaluations of each particular program and to initiate modifications in the recognized "essentials" for each particular specialty. However, it is the ultimate responsibility of the LCGME to approve these essentials and to review the accreditation recommendations of the RRCs.
3. The LCGME should have the authority to appoint one member to each RRC in place of the member currently appointed by the AMA Council on Medical Education. This member would be appointed from a roster of specialist educators developed by the AMA, the AAMC, and the AHA. The other two members of the LCGME (American Board of Medical Specialties and the Council on Medical Specialty Societies) are responsible for appointing the remaining members of the Residency Review Committees.

The Association responded on April 12, 1977.

On December 5, 1977, the Board of Regents of the American College of Surgeons sent copies of a letter addressed to the chairman of the LCGME to the parent organizations of the LCGME. This letter appears in the appendix of these minutes. It appears that some of the other parent organizations will respond to the letter, recommending that it be presented by the representative of the CMSS to the LCGME for consideration and response.



Action:

The Board recommended that the Executive Council ask the Association to respond to the American College of Surgeons recommending that the December 5, 1977 letter be presented by the CMSS representative to the LCGME for its consideration and response.

F. Report of the Committee on Physician Distribution

The Executive Council has considered the report of the CCME Committee on Physician Distribution regarding the specialty and geographic distribution of physicians on several occasions.

The final version of the report was submitted to the CCME on December 12, 1977 and approved and referred to the parent organizations for consideration.

Some members of the Board noted that the document contained little substance and concluded with a stand pat recommendation to study the matter further. They questioned the wisdom of such an approach at this late date, the informed public having been led to believe that the CCME had undertaken a serious study of the matter. Dr. Petersdorf opined that the claim that there is insufficient data upon which to base any substantive recommendations is not well founded: The two studies of internal medicine were generating a lot of data; the SOSSUS study produced first-rate data and together these efforts cover the preponderance of the career choices made. The problem is not a lack of data but a lack of acceptability to proposed solutions.

It was pointed out and generally agreed that a document with teeth in it could never be approved by both the AMA and the AAMC. Since the committee had been at work this long, we were almost bound to have a paper of some sort and this report appeared to be as acceptable as any likely to be produced.

Dr. Bondurant pointed out that the current report was essentially a planning document rather than one addressed to policy. If the title were changed to reflect this fact, the reader would be less likely to be let down upon discovering that it contained no policy recommendation.

Action:

The Board recommended that the Executive Council accept the report with the proviso that the transmittal letter point out that the report actually contained a description of an approach to policy development and recommended that the title be changed to reflect this fact.

## G. Ethics of Conducting Privately Sponsored Research in Academic Settings

On December 6, 1977, Mr. Rogers, Chairman of the House Subcommittee on Health and the Environment, wrote to Dr. Cooper, requesting his views on the propriety of publicly supported universities conducting directed research funded by profit-making manufacturers who have a direct economic interest in the research outcomes. Further, he asked: 1) what safeguards exist or could be instituted to assure expeditious disclosure of findings indicating potential serious adverse effects on public health; 2) whether a researcher has any ethical responsibility to disclose expeditiously any findings of such adverse effects, what monitoring mechanisms could assure that these responsibilities are carried out, whether a physician has any special responsibility; and 3) whether the AAMC had any ethical or legal codes addressing this matter and if no, whether such codes should be prescribed and enforced and by whom.

The AAMC had queried the institutions and the staff had completed a preliminary analysis of the responses. In general, the institutions have policies governing many aspects of sponsored research. They affirm for example, the right of the investigator to publish the results of his research. Most of the policies, however, focused on the business rather than the ethical aspects of sponsored research. Consultation, for example, was treated almost exclusively from this perspective. Sometimes, it was admitted, these policies were not strictly monitored and enforced.

The disclosure problem was not limited to prohibitions on publication. Indeed, this appeared to be hardly a problem at all. Rather, the volume of the data, the proportion of negative results and other factors mitigated against publication of much of the work in toxicity studies in refereed journals because of their own lack of interest. Thus, a response to the disclosure issue required a different approach than publication.

The Board discussed the matter at some length and concluded that the AAMC response should contain the following characteristics:

- Recognition of this matter as an important issue;
- A commitment to academic freedom and responsibility;
- Incorporation of our fundamental position into the Biomedical Research Policy Paper about to be considered;
- Exhortation to member institutions to set up formal policies in this area;
- Direction of the attention of Mr. Rogers and other to the responsibility of industry with some suggestions about how these might be better fulfilled.

Action:

The Board approved the recommendation that the Executive Council request the staff to develop a position paper on these issues for consideration by the Board and the Executive Council at their March meetings.

H. Cost Containment Program of National Steering Committee on Voluntary Cost Containment

Background

On November 2nd, U.S. Representative Dan Rostenkowski (D-Ill.), Chairman of the Subcommittee on Health of the House Ways and Means Committee, announced that his Subcommittee would be unable to act on proposals to limit hospital revenues and capital expenditures during the current session of Congress. In making his announcement, Rostenkowski stated: ". . . the period between now and the reconvening of Congress in January can be well spent by both the administration and the hospital industry in determining the best direction to take in achieving a means of containing hospital costs. For the administration, it is a time to reassess its proposal, to modify it where appropriate and to strengthen support for it both in the public and in the Congress. And because Congress has not passed legislation on the subject this year, the hospitals in this country have been given a brief grace period. With the knowledge that we will not resume consideration of the issue until early next year, hospitals have the opportunity to demonstrate that they can finally take the initiative and effectively and significantly restrain cost increases on a voluntary basis."

In response to Representative Rostenkowski's direct challenge, the American Hospital Association, the American Medical Association, and the Federation of American Hospitals formed a National Steering Committee on Voluntary Cost Containment to review and make recommendations regarding basic policy, directions, and guidelines for a voluntary cost containment program. A list of the members of the National Steering Committee is provided in the Appendix of these minutes. At its December 20th meeting, the National Steering Committee adopted, in principle, a fifteen point program for hospital cost containment which is set forth in the Appendix of these minutes. Included in the fifteen points is a recommendation that hospital and medical societies support and cooperate with the fifteen point program.

## Staff Discussion and Recommendations

### Voluntary Non-Governmental Cost Containment

The Carter Administration has chosen hospital cost containment as one of its major policy issues and has proposed legislation to establish a mandatory federal program of revenue and capital limitations for hospitals. The Association's position on the Administration's proposal is that a nationwide cap on hospital revenue and/or capital is unreasonable in the short-term and that it will have a highly adverse long-run effect. In lieu of the Administration's proposal the Association has advocated a six-point cost containment program which relies on local initiative, fully supported health planning, expanded utilization review, and reimbursement limitations which provide hospitals with incentives to limit operating expenditures. These positions are consistent with a voluntary approach to hospital and health care cost containment.

#### RECOMMENDATION

It is recommended that the Executive Council approve an AAMC position of strong support of a voluntary, non-governmental approach to hospital and health care cost containment provided that the specific voluntary program adequately reflects the varied circumstances of the nation's tertiary care and teaching hospitals.

While the Association supports a voluntary cost containment program, a state implemented plan based on national cost containment guidelines should recognize three specific concerns of the nation's teaching/tertiary care hospitals: manpower training costs, tertiary care service and capital costs, and institutionally based capital and operating expenditures.

#### Health Manpower Training Costs

Manpower education and training programs are not evenly spread across the nation's hospitals. Some hospitals engage in massive teaching and training programs while others either have no programs or only a few programs; some hospitals have fully developed and stable training programs while others either are expanding the size of their training programs or redistributing positions among the various programs. Unfortunately, the present statement of the National Steering Committee provides no guidelines recognizing the necessity or legitimacy of manpower training costs.

Document from the collections of the AAMC Not to be reproduced without permission

### RECOMMENDATION

It is recommended that the Executive Council approve an AAMC position to strongly recommend that the National Steering Committee and state implementing committees explicitly acknowledge and make appropriate allowance for changing hospital costs resulting from newly initiated, expanded, or reorganized manpower training programs which are accredited by an appropriate organization. Costs recognized should include faculty costs for educational instruction and supervision, costs for student stipends were provided, and costs for program support and institutional overhead.

### Scope of Services and Patient Mix

Recent and continuing attempts to concentrate high cost, tertiary care services in a limited number of hospitals have increased the scope of institutional services and the intensity of patient services in these hospitals. In the future, as communities and health planning agencies identify tertiary care services which are in short supply in their particular area, teaching/tertiary care hospitals will be expected to expand or introduce such short supply services. From a community perspective, this past and future concentration of tertiary care services is a reasonable and cost-effective policy; however, concentrating high cost services and patients may rightfully result in atypical operating cost increases and in large capital investment and start-up costs in tertiary care hospitals.

No recognition of these consequences of regionalization is explicitly provided in the program of the National Steering Committee.

### RECOMMENDATION

It is recommended that the Executive Council approve an AAMC position to strongly recommend that the National Steering Committee and state implementing committees explicitly acknowledge and make appropriate allowances for the impact of a hospital's approved scope of services and patient mix on its operating costs and capital expenditures.

### Non-Institutional Cost Controls

A voluntary cost containment program that focuses primarily upon the operating and capital costs of hospitals may inadvertently encourage salaried physicians to leave hospital-based practice for community-based practice, and it may stimulate the development of non-hospital diagnostic and treatment facilities which duplicate hospital-based services. Neither of these potential consequences is desirable from a long-run cost containment perspective.

### RECOMMENDATION

It is recommended that the Executive Council approve an AAMC position to strongly recommend that the National Steering Committee and state implementing committees adopt guidelines and procedures which do not discriminate economically against hospital-based physicians and patient services.

### Ambulatory Care

The original discussions of this program seemed to be focused on the cost of inpatient services. The revised draft discussion of cost screens, however, refers to the total hospital budget. The AAMC is concerned that in its member institutions which have large ambulatory care programs which need to be expanded to permit expansion of primary care training programs, there may not be sufficient flexibility in the 2% reduction target to permit the achievement of both objectives.

### RECOMMENDATION

It is recommended that the Executive Council express its concern that the National Steering Committee pay particular attention to its recommended screens to assure that they do not lead to a reduction of the growth of ambulatory services, particularly where such growth is essential to primary care training and to the achievement of other cost containment strategies.

### Discussion

Dr. Janeway pointed out several aspects of this program be considered disturbing. First is the explicit acknowledgement of the gap between the rate of increase of GNP and the rate of increase of hospital costs as a legitimate basis for comparison. The recommendation that this gap be reduced by 2% in one year (or forty percent of the current difference - 5% - between the two), bears no relation to anything meaningful. He suggested that it is inappropriate to compare increases in hospital costs with unweighted measures of GNP because health utilization of segments of the GNP are weighted differently than other factors in the derivation of the GNP.

The second explicit recommendation, to reduce capital investment in facilities and equipment to 80% of the annual (price adjusted) average of that during the 3 year period 1975 through 1977, is also very worrisome. It accepts an approach strongly objected to on principle when a part of the Administration's bill. Dr. Bentley pointed out that to have a credible program with the Administration

and Congress, a capital expenditures limitation was viewed as essential.

The Board also expressed great concern that experience indicates that such cost reductions are infeasible and thus, it is predictable that political forces will take the failure of the program as evidence of the necessity for federal legislation.

Several members pointed out that at least in many states, the issue had proceeded far beyond a voluntary approach and that mandatory strategies were already in place. In this situation, the effect of endorsing specific numbers would only be to establish the minimal expectation and probably result in standards more severe than if no numbers had ever been mentioned.

Since it seemed to be a political issue, it was suggested that the AAMC only speak to the four points recommended above by staff and deny any expertise in the overall standards setting issues. There was strong feeling that the AAMC not endorse the numbers and the timetables.

Dr. Gronvall also pointed out that the AAMC had endorsed planning and PSRO's which were in effect mandatory components of a cost containment strategy. Thus, he was surprised to see in the staff commentary that it was the AAMC position to be four-square behind voluntary cost containment strategies. Dr. Bentley pointed out that while we supported the strategies named, we also supported voluntary efforts by hospitals as a supplement to those activities.

In summary, what was omitted from the paper is important to us and what is proposed is infeasible, unworkable and unwise.

#### Action:

The Board voted to support the four stated concerns as a condition of any AAMC action and to await the advice of the COTH regarding the advisability of endorsing this specific voluntary program.

The Board also expressed its desire that any AAMC response on this, or position on cost containment matters generally, not permit the inference that the AAMC believed that a wholly voluntary effort, uncontaminated by any of the cost control strategies already legislated, would be an effective response to the problem.

#### V. Discussion Items

##### National Health Planning and Resources Development Act

The Board reviewed the Rubel paper, "National Health Planning and Resources Development Act, Implications for the Academic Medical

Center", distributed to the Council of Deans by pink memo #78-6. The discussion focused on considerations relating to the renewal of the legislation.

Drs. Krevans and Gronvall reported on the meeting of the Executive Committee with Congressional staffers preparing for the renewal of the health planning legislation. In general, the staffers viewed an extension of the program as a foregone conclusion, not subject to substantial deliberation. The changes contemplated would loosen rather than tighten (as the AAMC had hoped) the criteria of who would be eligible to represent the health professional schools on the HSA Board and the make up of the executive committee. Other changes would be directed toward making the HSA's more accountable to local government rather than freestanding and unaccountable entities. This was viewed as a constructive change which would increase the potential for consistency.

The Board discussion resulted in two strategies to guide the AAMC testimony. Rather than arguing that we should be left alone, we should push for appropriate recognition of the distinctions between M.D.'s and the requirements of their educational program and the other health professions. Secondly, we should urge that this planning approach be recognized as experimental and suggest the importance of developing criteria by which the success or failure of the effort might be measured.

#### VI. Report of the OSR Chairperson

Paul Scoles, OSR Chairperson, reported on the meeting of the OSR Board. In addition to items on the agenda of the Executive Council, the Board considered at length a strategy of getting better information into the hands of students attempting to select a GME program. The Board developed an approach which involved three components:

- 1) Work with Dr. Graettinger to expand the NIRMP booklet to include more factual information about the programs listed.
- 2) Work with the GSA to facilitate the development of a program at each school similar to that at Tulane in which recent graduates are asked to rate their GME program for the guidance of the students following.
- 3) Stimulate the development and publication of a helpful essay on "How to Select a Residency".



VII. Information Items

A. The Tentative Program for the COD 1978 Spring Meeting

The program was reviewed by the Board which was in nearly final form with several speakers yet to be confirmed.

B. COD Government Issues Identification Survey

The preliminary results of the survey were published in the agenda book. The range of issues elicited was very broad with no single item of overwhelming concern to a large proportion of the Council. Cost containment, state rate review, planning and general concerns relating to the financing of medical education rated among the most often cited issues.

C. Resignation of the Chief Medical Director of the VA

Dr. Van Citters noted that Dr. Chase is resigning as Chief Medical Director of the VA and suggested that he be advised of appropriate nominees for the position, so that as a member of the VA Special Medical Advisory Group he could facilitate appropriate consideration of desirable candidates. Dr. Cooper noted that the AAMC had already solicited the deans for suggestions.

D. Closing of USPHS Hospitals

Dr. Van Citters informed the Board that there will be another push to close the Public Health Hospitals.

E. The Score in Pasadena

Dr. Van Citters provided, as a matter of information, the score of Rose Bowl Game: U. of Washington - 27, U. of Michigan - 20. Dr. Gronvall reported that as a true scientist, he had plotted scoring against time and had demonstrated that the ultimate outcome of the game would have been quite different over a greater time.

F. Impact of the Social Security Tax Increase

Dr. Janeway asked whether anything could or should be done to mitigate the effect of the tax increase on our institutions. Dr. Sherman noted the AAMC efforts in conjunction with the ACE to support an amendment to the bill. This was unsuccessful but did result in blocking an even more unfavorable outcome.

Dr. Janeway pointed out that 501 (c)(3) organizations had the option of dropping out of the Social Security System and recommended that thought be given to this possibility.

VIII. Adjournment

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

## COORDINATING COUNCIL ON MEDICAL EDUCATION

## Member Organizations

American Board of Medical Specialties  
1603 Orrington Ave., Evanston, Ill. 60201

American Hospital Association  
840 N. Lake Shore Dr., Chicago, Ill. 60611

American Medical Association  
535 N. Dearborn St., Chicago, Ill. 60610

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

Council of Medical Specialty Societies  
P.O. Box 70, Lake Forest, Ill. 60045

## Office of the Secretary

P.O. Box 7586  
Chicago, Illinois 60680  
(312) 751-6299

December 16, 1977

To: American Board of Medical Specialties  
Glen R. Leymaster, M.D., Executive Director

American Hospital Association  
Mr. John Alexander McMahon, President

American Medical Association  
James H. Sammons, M.D., Executive Vice President

Association of American Medical Colleges  
John A. D. Cooper, M.D., Ph.D., President

Council of Medical Specialty Societies  
Richard S. Wilbur, M.D., Executive Vice President

From: Jackson W. Riddle, M.D., Ph.D.  
Secretary, Coordinating Council on Medical Education

Re: Activities of the Committee on Future Staffing

-----

At its December 12 meeting the Coordinating Council on Medical Education discussed the November 21 meeting of the Committee on Future Staffing and defined five possible methods of staffing the CCME and/or its Liaison Committees. The following options were delineated:

1. Rotating Secretariat
  - A. CCME alone
  - B. CCME and Liaison Committees -- without supervision of accreditation staff (total package or sequentially)
  - C. CCME and Liaison Committees with supervision of accreditation staff
  - D. CCME and one or more Liaison Committees

2. Permanent assignment of secretariat among various organizations -- with or without accreditation staff

( e.g. - LCME to AAMC )  
( LCGME to ABMS )  
( LCCME to CMSS )  
(proposed - LCAHE to AMA )  
( etc. )

3. Independently Incorporated Board of Directors appointed by the five parents
  - A. Directors would appoint and supervise all staff for CCME and all Liaison Committees (similar to JCAH, ECFMG, etc.).
  - B. Directors would contract arrangements with an outside organization such as Rand, I.O.M., Arthur D. Little Co., to perform all staffing functions.
4. Separate and independent arrangements for each organization -- CCME, LCCME, LCGME, LCME (individual corporations with separate staffs).
5. Continue the present arrangement with the AMA providing staffing services.

The CCME requested staff to send these options to the five parent organizations for consideration and comment. If you wish to also consider the cost implications, financial information has been provided to the Committee on Future Staffing in the past.

# American College of Surgeons

55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611

AREA CODE 312 — 664-4050 CABLE AMERCOLSUR

5 December 1977

Russell S. Fisher, M.D.  
 Chairman  
 Liaison Committee on Graduate Medical Education  
 535 North Dearborn Street  
 Chicago, Illinois 60610

Dear Dr. Fisher:

The Board of Regents of the American College of Surgeons wishes to express to the LCGME and the sponsoring organizations of the LCGME its continuing concern regarding the interrelationships of the surgical Residency Review Committees and the LCGME. As Chairman of the Board of Regents of the American College of Surgeons, I originally expressed these concerns in my letter dated 4 March 1977.

The Executive Committee of the Graduate Education Committee, discussing the matter in late May, studied all organizational responses to the above letter. Thereafter, this Executive Committee submitted the following recommendation:

The Graduate Education Committee should discuss, consider, and develop, at its October 1977 meeting, a new mechanism for approval of graduate education programs in the surgical specialties, providing a satisfactory response has not been received from the LCGME or the CCME to Dr. Muller's letter dated 4 March 1977.

At its October 1977 meeting, the Graduate Education Committee decided that a satisfactory response and corrective action in the committee's interrelationships had not been made, in line with the recommendations contained in my March 4 letter to the LCGME. Thereafter, the following recommendations were presented to and approved by the Board of Regents of the American College of Surgeons in October 1977:

1. The Graduate Education Committee endorses the concepts that the LCGME shall
  - a. serve as the appeals body with regard to the surgical specialty residency training programs

# American College of Surgeons

Russell S. Fisher, M.D.

5 December 1977

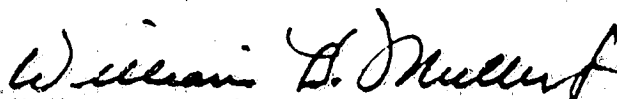
Page 2

- b. receive independent staffing
  - c. include a number of voting members (preferably three) with service on the Specialty Boards or Residency Review Committees.
2. That the individual Residency Review Committee for each of the several surgical specialties shall function as the accrediting authority under the auspices of its appropriate sponsoring parental organizations.
  3. Policy statements may be enunciated by the Residency Review Committee. Such statements must have the approval of the parental sponsoring bodies of the Residency Review Committees. It should be specified that the "General Essentials" would be designated as policy. Communications regarding other matters not considered as policy should be made directly by the LCGME to the parent bodies of the Residency Review Committees. Among such matters would be the "Special Requirements", "Structure and Functions", and "Guide". In this way, these considerations would, therefore, not need to proceed beyond the Council on Medical Education in the AMA approval process.
  4. In consideration of these deliberations, the Graduate Education Committee finds the draft of the LCGME, entitled "The Essentials of Graduate Medical Education", dated July 25, 1977, to be inappropriate. The Graduate Education Committee would be willing to participate in rewriting this document, considering these recommendations made above under items 1, 2, and 3.

I have received your 28 October 1977 letter. The American College of Surgeons Graduate Education Committee and the Board of Regents have been aware of the initial agreements of 25 January 1972 and the proposal for establishment, dated 30 March 1972, to which you refer. These documents do not contain answers to the questions presented in my letter of 4 March 1977.

I am looking forward to a definitive response.

Sincerely,

  
William H. Muller, Jr., M.D., F.A.C.S.  
Chairman, Board of Regents

NATIONAL STEERING COMMITTEE ON  
VOLUNTARY COST CONTAINMENT

Samuel Tibbitts  
Chairman-Elect, American Hospital Association  
President, Lutheran Hospital Society of Southern California

Andrew W. Miller  
President-Elect, The Federation of American Hospitals  
Senior Vice President, Hospital Corporation of America

Robert B. Hunter, M.D.  
Chairman of the Board of Trustees, American Medical Association  
Sedro Wooley, Washington

Robert Froehlke  
President, Health Insurance Association of America

Harold Buzzell  
President, Health Industry Manufacturers Association

Walter McNerney  
President, Blue Cross Association

Mrs. Virginia Knauer  
President, Virginia Knauer and Associates

C.S. Tsorvas  
Consultant for Insurance Plans and Corporate Employee  
Relations, General Electric Corporation

ACTIONS APPROVED BY THE  
NATIONAL STEERING COMMITTEE ON  
VOLUNTARY COST CONTAINMENT

December 20, 1977

1. Affirmed the action taken by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals urging the creation of state-level voluntary cost containment committees, to be established through the leadership of the state hospital association, the state medical society, and investor-owned representatives. The first task for each state committee should be to consider the guidelines and recommendations below and then develop a proposal for an action program tailored to meet the needs of the state. The state committee should submit its proposed program to the National Steering Committee for its review and response.
2. Affirmed the action called for by the American Hospital Association in its November 23, 1977 mailgram to member institutions, calling for an immediate reassessment by each institution of planned budget and charge adjustments to be implemented beginning January 1, 1978, to see if anything further can be done in the short term to reduce these increases, consistent with sound medical practice.
3. Established as the national goal of this voluntary cost containment program a significant reduction in the rate of increase in health care costs. As the first step in the achievement of this goal, the rate of increase in hospital expenditures must be reduced over the next two years, so that the gap\* between this rate of increase and the rate of increase in the GNP (including both real growth and inflation) can be significantly narrowed. This first step toward the goal can be achieved by establishing a national objective of reducing the annual rate of increase in non-federal short-term hospital expenditures by 2 percentage points each year during 1978 and 1979. This annual objective, of course, must be monitored in relation to inflationary trends, wage and salary policies, and energy costs in the economy as a whole, and may need to be modified either upward or downward if the economy changes direction. Modification of the annual objective, however, should not deter movement toward the goal of reducing the gap between increases in hospital expenditures and the gross national product.
4. Provisionally adopted\*\* the following interim guidelines for consideration by (a) hospitals for reassessing their current budgets, and (b) the state voluntary cost containment committees. The interim guidelines\*include the

\*This gap, based on September 1977 data, is now approximately 5 percentage points.

\*\*Subject to review by legal counsel.

\*Where an individual institution is part of a multi-hospital system, these guidelines and screening criteria should be applied to that system's hospitals within the state.



following:

- a. All hospitals are urged to reduce the rate of increase in the institution's budget for the fiscal year beginning any time after September 30, 1977 to as low a rate as possible, consistent with sound medical practice. Even where hospitals are already below the national average, special efforts are needed to achieve further reductions wherever possible.
- b. For the state level program, each state should consider the national goal noted in 3 above and develop an action program that is consistent with this goal. A special assessment of the particular situation in the state should be made by each state committee because the rate of increase and the current level of hospital expenditures vary widely from state to state and from hospital to hospital within each state. In developing its program, the state committee should consider what rate review and control activities, governmental or voluntary, currently exist.

In structuring their review program, states should consider--

- (1) The establishment of a screen to identify for review any hospital with a rate of increase in its budgeted revenues or expenditures for the fiscal year beginning any time after September 30, 1977 that is not at least 2 percentage points (or some comparable percentage) below the rate of increase in the previous fiscal year.
- (2) In addition to the above, the establishment of a screen to identify for review any hospital in the top 15 percent (or some comparable percentage) of all hospitals in the state; based on the projected rate of increase in revenues or expenses per admission for the fiscal year beginning any time after September 30, 1977, or a screen to identify for review any hospital whose projected revenues or expenses per admission for the fiscal year beginning any time after September 30, 1977 will increase in excess of 10 percent (or some comparable percent based on the particular situation in the state).

In implementing the review program, the state committees should call upon the board of each hospital in the state to adopt a resolution establishing appropriate budget goals for the institution's coming fiscal year, consistent with the national goal, state program, and these interim guidelines. If a hospital's board adopts such a resolution, upon submission of the resolution to the state committee, that hospital should be provisionally certified as a cost containment hospital and not subject to interim prospective budget review by the state committee. Periodic monitoring by the state committees should assure continued performance by such institutions.

The state committees also should ask every hospital to voluntarily report key indicators to the committee, for example, number of admissions, total expenses, total revenues, average length of stay, number of beds, and capital expenditure plans. These figures should be voluntarily reported by every hospital for the next fiscal year beginning after September 30, 1977 and also for its previous fiscal year.

The state committees should develop a plan to work with each hospital falling into the foregoing categories to identify ways in which these hospitals can voluntarily reduce their rate of increase. Each state committee also should periodically report the details of its cost containment program to the National Steering Committee. AHA, AMA, and FAH should offer their help to the state committees to assure an appropriate contribution by each state to the achievement of the national goal and objective.

THE RECOMMENDATIONS ABOVE ARE PROVISIONAL RECOMMENDATIONS OF THE NATIONAL STEERING COMMITTEE, PENDING REVIEW BY APPROPRIATE LEGAL COUNSEL. THE NATIONAL AND STATE GOALS AND OBJECTIVES, INTERIM GUIDELINES, AND SCREENING CRITERIA ARE TO BE USED SOLELY AS GUIDELINES FOR EACH HOSPITAL TO ASSESS ITS OWN BUDGET, AND FOR STATES IN IDENTIFYING HOSPITALS WHERE A SPECIAL REVIEW IS NEEDED. THESE FIGURES ARE NOT TO BE CONSIDERED AS FLOORS OR CEILINGS.

5. Provisionally adopted\* a primary national goal of significantly reducing new capital investment over the next two years, concentrating on two objectives. First, in 1978 there should be no net increase in the total stock of hospital beds as of December 31, 1977, adjusted for any new beds that might be added due to certificate of need or 1122 approvals that were granted prior to December 31, 1977. Second, there should be a reduction in 1978 in total new capital investment approved under certificate of need and 1122 review programs to 80 percent of the annual (price adjusted) average of the approved capital investment in hospital facilities and equipment during the 3-year period of 1975 through 1977. Because of the cyclic nature of certain capital expenditures, and the lack of a sound data base in this area, the 1979 objectives will be developed in mid-1978.

In carrying out programs to achieve these goals and objectives, state committees should develop cooperative working relationships with the appropriate state and local agencies.

Interim guidelines for all hospitals and for the state committees include the following:

- a. All hospitals are urged to reassess their capital budgets to see if any further reductions can be achieved either through the development of alternatives to capital investment or reductions or postponement

\*Subject to review by legal counsel.

of capital spending.

b. In structuring their capital expenditure programs, states should consider--

(1) That the national objectives of holding the line on the stock of beds and of reducing total new capital investment should not be interpreted by the states as a floor or ceiling. Rather, state committees should work with the appropriate state and local agencies to assess the unique and special needs of that particular state, for example, to reflect the areas that are subject to a rapidly growing or substantially changing population base, or to eliminate (or convert to other uses) excess bed capacity where it is identified. Elimination or conversion of excess bed capacity should be achieved with full consideration of due process to the affected institutions and should be predicated on appropriate consideration for invested capital and associated debt service remaining.

(2) The national goal and objectives outlined above should be coordinated with the planning review and certificate of need process, so that each institution's application for review and approval is both submitted and reviewed in light of its potential impact on the national and state goals and objectives.

(3) The state committees should establish liaison with the appropriate state and local agencies in implementing this program.

6. Requested that all hospital medical staffs reaffirm their commitment to carry out effective, ongoing, voluntary utilization review programs to assure the efficient provision of services and wherever possible, and consistent with sound medical practice, all hospital medical staffs should consider ways to further tighten utilization review programs. Implementation of the utilization review programs should involve close cooperation of the medical staff, management and board.
7. Called for an expanded study and development by the state committees of programs to significantly improve productivity in hospitals, including the development of appropriate standards for effective measurement of productivity gains. The objective of each hospital over the next 2 years should be an improvement in productivity of at least 2 percent per year.
8. Called for an acceleration in the current trends to improve the health delivery system through multi-hospital systems, shared services, emphasis on primary care accessibility, and multiple avenues for the effective delivery of health services thorough single and multi-specialty medical groups and alternate delivery systems.

9. Called for the immediate direct communication of the above-stated objectives and interim guidelines for this voluntary cost containment program through a letter or mailgram signed by the chief executive officers of the American Hospital Association, the American Medical Association, and the Federation of American Hospitals to all hospital chief executives, all chiefs of medical staffs, all hospital board chairmen, all state hospital and medical societies, and all other allied associations, urging their support and cooperation with this program.
10. Called upon the American Hospital Association, the American Medical Association, and the Federation of American Hospitals to develop technical assistance programs, based on directions and recommendations of the National Steering Committee, to assist both state committees and hospitals in meeting the objectives of the program, including the immediate development of guidelines to assist the newly-formed state-level committees in carrying out their activities.
11. Urged each hospital supplier to support the voluntary cost containment program and to independently exercise restraint in its pricing policies, and urged each hospital purchaser independently to resist extraordinary high price increases.
12. Decided to develop a program on public education, including the development of approaches to explain to the public the voluntary cost containment program and the impact of increased demand for hospital and health care services. The public education program also will include ways to actively involve consumers, providers, trustees, industry, labor and others in the effort to contain hospital and health care costs and to improve the public understanding of the reasons for cost increases.
13. Called upon the chief executive officers of the American Hospital Association, the American Medical Association, and the Federation of American Hospitals, as well as the members of the National Steering Committee, to establish contacts with the Department of Health, Education and Welfare, the Council on Wage and Price Stability, congressional leaders, and the White House with respect to the voluntary cost containment program goals, objectives, and interim guidelines, for the purposes of obtaining a broad base of support and cooperation for this voluntary effort. These contacts also should extend to industry and labor.
14. Called upon insurance carriers, other purchasers of care (public and private), industry and organized labor to examine cost-effective alternatives to existing health insurance programs, including expanded consumer cost sharing and other approaches to heighten the awareness of the health care consumer regarding the cost of health care. New insurance benefits or substantial expansion of existing coverages should be carefully assessed on the basis of their cost-effectiveness and inflationary impact, based on the national goals, objectives, and interim guidelines of this program. Various incentive payment programs should be developed by providers and purchasers of care. Insurance carriers and government should examine ways to further reduce their administrative costs in carrying out their activities.

15. Called upon the Department of Health, Education and Welfare and other national and state agencies to carry out cost-effectiveness studies regarding all existing regulations that have a substantial impact on the health care industry, to be completed by the end of 1978. An in-depth analysis of the cost-effectiveness and inflationary impact of any proposed health care legislation and regulations, and of the overall regulatory structure in the health care industry, also should be carried out.

12/21/77

WORKLOAD PROBLEMS IN THE DIVISION OF RESEARCH GRANTS  
OF THE NATIONAL INSTITUTES OF HEALTH

The attached paper, prepared for the Intersociety Council for Biology and Medicine, sets out some of the problems that Dr. Douglas will discuss with the Board. He has asked that it not be given broader distribution until after discussion.

DISCUSSION OF WORKLOAD PROBLEMS IN  
DIVISION OF RESEARCH GRANTS  
NATIONAL INSTITUTES OF HEALTH

Prepared For

Representatives of Intersociety Council for Biology and Medicine

THE PROBLEM

Beginning in about 1969 a remarkable increase in the rate of submission of research grant applications by the scientific community occurred. This rate of increase is continuing. The number of applications submitted has now reached more than twice the level it was in 1969. With no appreciable increase in the number of Study Sections or Study Section members over the same period, the integrity of the peer review system is now under serious threat. The overload on Division of Research Grants' (DRG) Study Sections is steadily diminishing the quality of the scientific review. This discussion sets forth for the Intersociety Council information on the magnitude of the problem, provides some insights into factors contributing to it, and describes our attempts at alleviation.

In 1969 the DRG reviewed 8,227 applications; in 1977 the number reviewed was 17,741, or more than twice as many. The number of personnel in the Division decreased from 425 in 1969 to 392 in 1977, however. Over this same time the number of Study Sections increased only from 48 to 50, and the number of Study Section members grew from about 690 to 789. In sum, while the workload more than doubled over the 8 year period, the number of Study Section members to perform reviews increased only about 15 percent, although it must be acknowledged that the Division has increasingly relied on Special ("ad hoc") Study Sections, and "ad hoc" reviewers. (See attachment.)

Some Study Sections have been more heavily burdened than others. Those in which the number of applications more than doubled include the following: Applied Physiology and Orthopedics; Biochemistry; Cardiovascular and Pulmonary; Cardiovascular and Renal; Developmental Behavioral Sciences; Epidemiology and Disease Control; Experimental Therapeutics; Genetics; General Medicine B; Neurology B; Neurological Sciences; Pathology A; Pathology B; Radiation; Reproductive Biology; Toxicology; and Special Study Sections.

We have examined certain characteristics of the increased workload to attempt to understand it and to develop appropriate means of alleviating the problem. For example,

- there are no discernible marked changes from 1969 to 1977 in the patterns of rates of submission of applications when we examine the top 50 institutions, the states, or the regions;
- the number of amended applications per round has remained relatively constant from 1969, ranging from about nine to twelve percent, although in some Study Sections the rate has exceeded 20 percent;

- neither the average number of competing grant applications submitted per investigator, nor the average number of grants awarded per principal investigator (PI) has changed dramatically in the years we reviewed (early 1970's on);
- DRG-reviewed applications have more than doubled for the following BID's from 1969 to 1977: National Eye Institute; National Cancer Institute; National Institute of Environmental Health Sciences; National Heart, Lung, and Blood Institute.

The first three findings are not helpful in explaining the increased workload. The last point, however, is significant.

#### FACTORS CONTRIBUTING TO WORKLOAD AND QUALITY OF REVIEW

Among the factors that contribute directly or indirectly to workload of DRG staff and of Study Section reviewers are new initiatives for accountability (e.g., Sunshine Laws, Human Subjects Regulations), BID programming efforts in response to Congressional mandates, and trends toward increased targeting. Executive Secretaries of Study Sections and initial reviewers must now be concerned with extensive documentation in the applications and perform detailed reviews against applicable guidelines regarding human subjects, animals, and recombinant DNA. About one-third of all NIH applications involve human subjects. The number of applications involving recombinant DNA received for the January 1978 council round was approximately 100.

For the three council rounds in 1977, there were 47 Requests for Applications (RFA's) and Program Announcements generated by Public Health Service research components (principally NIH) that increased the number of applications for which central referral and, in many cases, review resources in DRG were required.

With increased emphasis in 1979 on "basic" research in this "year of the R01," the workload for DRG will not diminish.

Other strains on the peer review system are creating pressures for DRG staff and reviewers. Under DHEW's interpretation of the Privacy Act of 1974, summary statements may be released to PI's prior to council. Between the June 1977 Study Section meetings and the October 1977 council round, approximately 1280 summary statements were released to PI's. This release resulted in some 77 communications to NIH before council rebutting information or requesting amendment to key documents. Current HEW policy on release of summary statements means that often Executive Secretaries are called for information while they are preparing the summary statements, resulting in use of their already limited time and jeopardizing the confidentiality of outside opinions and the opinions of individual reviewers. More disruptive than the release of the summary statement will be the consideration of the communications that come to NIH from the PI after receipt of the summary statement and prior to the council meetings. We expect these communications to increase just as requests for summary statements increased once PI's knew of their availability.

The NIH has recently announced to the public the NIH Director's decisions on the recommendations of the Grants Peer Review Study Team. Summary statements with priority scores will be sent routinely to the PI after council. With this announcement, and pending development of internal implementing procedures, NIH plans to request PI's to wait for NIH's automatic transmittal of summary statements after council in lieu of making requests while the peer review process is in progress.



The Intersociety Council could be helpful in informing its members of our request. AAMC staff is also working with us in reviewing legislation and legal decisions on which our current Privacy Act policies are based.

#### IMPACT OF WORKLOAD

The increased number of applications, the increased documentation required, and other strains on the peer review system have lowered morale of both internal staff and reviewers. Although not easily measured, the potential for lowered quality of review and eroded integrity of the system is an effect of the unprecedented workload. We estimate that 3 workweeks (or 120 hours) of unremunerated detailed study and preparation of reports must be given by each reviewer for each round under optimum conditions. At present, some Study Section reviewers have 20 applications per round for which they are responsible as primary or secondary reviewers. The choices are to ask more of our reviewers; to decrease review time for each application; or to continue to maneuver "ad hoc" reviews--the technical legality of which may be open to question.

The workload increase has taken its toll in a measurable way by increasing the resignation rate of Study Section members. In FY 1974 the percentage resignation was 0.6 percent of total membership; in FY 1975 it increased to 2.6 percent; in FY 1977 it was 3.9 percent, a percentage we estimate will be about the same in FY 1978. Reports are that the same professional societies have advised potential Study Section members about the plight of DRG and has questioned the desirability of Study Section appointment under current workload conditions.

#### ATTEMPTS AT ALLEVIATION

In June 1977 we began systematically considering ways to reverse the DRG workload trend. We discussed most of the alternatives we considered with a group of 12 Study Section chairmen in November 1977. With little or no possibility of increased personnel ceilings, we have attempted to increase manpower by using expert consultant positions loaned from the National Heart, Lung, and Blood Institute. We have also considered loans from the intramural program, intergovernmental personnel agreements (IPA's), and use of "when actually employed" (WAE) and temporary personnel.

Another approach we have considered is the imposition of limits on:

- . the number of pages in an application;
- . the number of applications submitted per investigator per year;
- . the number of different "activity types" of applications per investigator (e.g., Program Project, Research Career Development)
- . the number of revisions of applications; and
- . most dramatically, the number of applications to be reviewed at a single Study Section round, i.e., the establishment of a "queuing" mechanism.

Although we plan to continue considering the possibility of implementing some of the approaches listed above, we recognize that some of these may be unsatisfactory, either because they will have no real impact on workload; will cause more processing or workload problems than would be solved; or would have an inappropriate effect on the principles on which peer review is conducted and meritorious projects selected.

There are several other actions that may be helpful. These include eliminating waivers of receipt dates for new applications; devising a way to prepare less detailed summary statements; working with the National Science Foundation to find more efficient means of dealing with applications submitted to both agencies.

One hopeful event is a discussion Dr. Fredrickson had with representatives of the Office of the Secretary, HEW, about Flexible Study Sections. HEW officials have indicated a willingness to entertain the concept of this type of Study Section. Our proposal is that about half of the existing Study Sections and all future Study Sections be chartered to include two or more subcommittees in the Study Section. Membership would increase from approximately 18 to 36 reviewers. We see many advantages of the Flexible Study Section concept for NIH. Details of the charters for four Study Sections are now under consideration: Genetics, Radiation, Chemical Pathology, and Reproductive Biology.

#### CONCLUSION

There are conceptually two approaches to dealing with the workload situation. The first would involve expanding the capacity of the review system in terms of DRG resources and the number of Study Section reviewers. A related approach would be to make adaptation of the system at its current capacity; however, if we are to retain valuable features of the system, the options are distinctly limited. The staff of the NIH are working toward relief along both these avenues, i.e., expanding the capacity and improving the efficiency of the system.

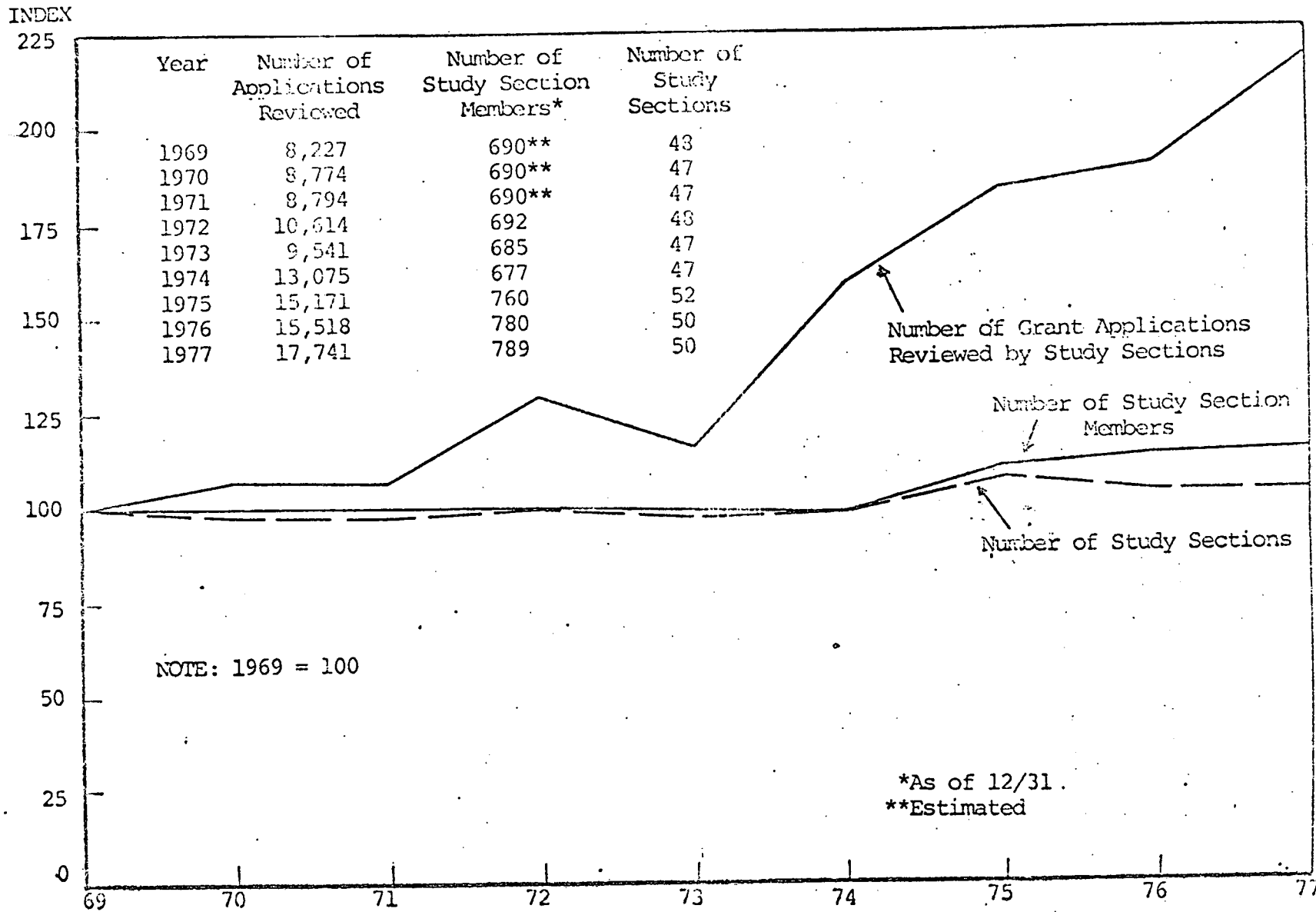
Another means of modifying the current pressure will require a moderation in the rate of influx of applications. We would also hope to decrease demands from the applicant community and the Federal establishment for services from the system that divert its resources from its primary task of performing quality review of the scientific content of the proposed research. It is in this area we seek understanding and cooperation from the scientific community. We would ask, for example, that the research institutions help in developing a reasonable plan of action, including, for example--

- requesting principal investigators to wait until after council before requesting information about the recommendations on their applications;
- screening the applications to assure that they are complete and well-presented;
- exploring ways to limit applications by other means.

Enclosure

February 22, 1978

GROWTH RATES OF APPLICATIONS REVIEWED, STUDY SECTION MEMBERSHIP  
AND NUMBER OF STUDY SECTIONS, FY 1969 - 1977  
DRG STUDY SECTIONS



MEDICAL SCHOOL ADMISSIONS CRITERIA

The attached excerpt from the January 3 issue of the United States Law Week was brought to our attention by Dr. Van Citters, who suggested that it be discussed by the Board.

The following article from the March 15 issue of the New York Times deals with a related issue.

the court notes that there is substantial authority suggesting that a 42 U.S.C. §1983 action lies to redress federal statutory as well as constitutional claims. Since the Fees Act authorizes fee awards in any Section 1983 action, courts may well be empowered to grant fees to parties prevailing on federal statutory claims. (Page 2329)

### **Statutory Exemption To Obscenity Law Runs Afoul Of Equal Protection Clause**

A Maryland adult bookstore clerk discovers that the First Amendment is not the only weapon he has to fight a conviction under that state's obscenity statute. He convinces the Maryland Court of Appeals that the law, which exempts movie theater employees from prosecution, denies him equal protection rights guaranteed by the Fourteenth Amendment. (*Wheeler v. Maryland*, 12/12/77)

To be valid, the exemption of movie theater employees would have to rest upon some ground of difference having a fair and reasonable relation to the statutory purpose of prohibiting the publication, printing, sale, and distribution of obscene matter. A state lower court found a "rational basis" for the exemption because movie theater employees, except for the projectionist, ordinarily do not come into physical contact with the items sold. Furthermore, while controls may be placed so as to regulate the age of all who enter a theater to see a film, no such controls are present when obscene material is removed from the bookstore premises.

The court of appeals disagrees. It fails to see the relevance of the degree to which the obscene matter is handled by the employees. Even if movie theater employees do not come into physical contact with the material, they are furthering the distribution of it. Nor does the juvenile rationale constitute a reasonable basis for the classification. Moreover, the statutory language cannot be read so that the exemption pertains only to the showing of the film itself. An usher who distributes a program that in itself is obscene would not be subject to the prohibitions of the statute, while a bookstore employee who distributes the same program could be punished under the law. Thus, the court concludes, the law operates on some persons and not upon others similarly situated. (Page 2330)

### **Medical School's Admissions Criteria Are Basis Of Contract And Fraud Suit**

An aspiring medical student who claims that his application to medical school was rejected because neither he nor his family could afford to make a monetary contribution to the school, the Illinois Supreme Court says, can maintain an action for breach of contract based on the medical school's failure to evaluate his application according to the

academic criteria described in the medical school's bulletin. Moreover, the court says, the unsuccessful applicant also has a cause of action for common-law fraud premised on the medical school bulletin's alleged misrepresentation concerning admissions criteria that induced prospective students to pay the \$15 application fee. (*Steinberg v. Chicago Medical School*, 12/12/77)

The bulletin stated that each student's potential for the study and practice of medicine would be evaluated on the basis of academic achievement, standardized test scores, and personal appraisals. The medical school's acceptance of an application and the \$15 application fee constituted acceptance of an offer to apply under criteria established by the medical school. The unsuccessful applicant's allegations that the medical school failed to live up to its part of the bargain, the court says, thus state a cause of action for breach of contract.

The unsuccessful applicant also claimed that the university intentionally deceived applicants and induced them to pay the \$15 application fee by stating in its catalog that it would use certain criteria to evaluate the applications, when, in fact, applicants were selected primarily for monetary considerations. Allegations of misrepresentation of an existing material fact, coupled with scienter, deception, and injury are adequate to support a cause of action for common-law fraud, the court finds. It is immaterial that the misrepresentation here consisted of statements referring to the medical school's future conduct. Liability can be found, the court states, where the false promise or future representation of conduct is alleged to be the scheme employed to accomplish the fraud. (Page 2336)

### **Liquor Dealer's Illegal Rebates Are Part Of Cost Of Goods Sold**

Credits given by a wholesale liquor dealer to selected customers, in violation of state law requiring sales only at posted prices, constitute part of the cost of goods sold and therefore reduce the dealer's gross income, the Tax Court rules. The credit, which the customers can use to purchase additional liquors, or the additional bottle that the customers get for each case purchased, is not a deduction that may be disallowed under Section 162(c)(2) of the Internal Revenue Code as an illegal business expense. (*Max Sobel Wholesale Liquors v. Comr.*, 12/15/77)

The practice of making illegal rebates first came before the Tax Court in a case involving milk sales in violation of state law. In *Pittsburgh Milk Co. v. Comr.*, 26 T. C. 707 (1956), the court distinguished between a discount or rebate to which the customers became entitled at the time of sale and costs incurred in the form of illegal payments or payments to third parties that were not made pursuant to agreement between the buyer and the seller. Where the rebate was

Tuesday, March 15, 1978

## Student Paper Says Boston University Sells Admissions

By MICHAEL KNIGHT

Special to The New York Times

BOSTON, March 14—A Boston University student newspaper said today that it had uncovered a university policy of selling admissions to medical school and to law school to wealthy applicants.

The newspaper, BU Exposure, printed script of a board of trustees subcommittee meeting five years ago at which John R. Silber, the president of the university, had specifically approved the policy as a fund-raising device.

Mr. Silber called the newspaper's charges deliberate lies and denied that any such policy existed. "No one has been admitted to Boston University in consideration of the payment of money," he said. "No one has ever bought a place in one of our schools."

The exchange of charges between Mr. Silber and the politically oriented student newspaper is the latest in a series of

conflicts that has already resulted in one lawsuit.

It was unclear today whether the charges, if proved true, constituted an illegal action by the university, the nation's fourth-largest private educational institution with 16,000 students. But it would constitute an embarrassing exposure of a practice in higher education that is sometimes hinted at but rarely documented. In addition, the charges would prove damaging to Mr. Silber, a teacher of philosophy who is a leading spokesman for private higher education as well as a proponent of ethics and liberal values.

The newspaper reprinted parts of a 100-page transcript of a meeting of the university's Select Committee on University Needs that was held on Oct. 13 and 14, Silber told the committee: "There has been any number of people crawling all over me for admission to our medical school and our law school who have not been tapped systematically for gifts to this university. I'm not ashamed to sell those indulgences."

### Policy Called 'Extortion'

The newspaper quotes Louis Rosenfield, an honorary trustee, as responding by saying: "John, I'm very happy you've got this boy into law school I demanded \$50,000 and I was greatly criticized." The newspaper reported that "no member of the committee objected to that policy."

The newspaper, which characterized the policy as "extortion" that discriminates against poor people and members of minority groups, went on to quote Mr. Silber as responding that the university does not accept unqualified students. But it quoted him as saying that the university "should go to the right person, the father of the person who has been admitted, and talk to him about a major gift to the school."

Mr. Silber, who could not be reached for comment today but who instead distributed a prepared rebuttal, accused the newspaper of publishing "snippets carefully chosen so as to distort reality and provide a basis for their vicious and false use of the term extortion."

Mr. Silber denied the paper's assertion, based on the transcript, that a member of the board of trustees had charged an applicant \$50,000, to be paid as a gift to the university's \$30 million endowment. "That statement is false," he said. "Moreover, no such statement appears in the transcript. Again, the Exposure group, who are in a position to know what was said in the transcript, must have deliberately lied."

The newspaper called for a Congressional investigation and urged that all graduates of the university law school and medical school since 1973 be subpoenaed to testify about possible payments.