

Sept 21-22, 1983

FUTURE MEETING DATES

1983 AAMC Annual Meeting

*November 5-10
Washington Hilton Hotel
Washington, D.C.*

1984 COD Administrative Board/Executive Council

*January 18-19
April 11-12
June 13-14
September 12-13*

1984 COD Spring Meeting

*April 1-4
Callaway Gardens
Pine Mountain, Georgia*

COUNCIL OF DEANS
ADMINISTRATIVE BOARD

Wednesday, September 21, 1983
5:30 pm - 7:00 pm

Washington Hilton Hotel
Washington, D.C.

AGENDA

I. Discussion of PGY-2 Issue

Thursday, September 22, 1983
9:00 am - 1:00 pm

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II. Report of the Chairman	
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IV. Action Items	
A. Election of Distinguished Service Members	9
B. Blacks and the Health Professions in the 80s: A National Crisis and A Time for Action (Executive Council Agenda-----p. 23)	
C. COTH Membership Criteria (Executive Council Agenda-----p. 24)	
D. ACCME "Protocol for Recognizing State Medical Societies as Accreditors of Intrastate CME Sponsors (Executive Council Agenda-----p. 26)	
E. Issues Related to Appointment to PGY-2 (Executive Council Agenda-----p. 34)	
F. Principles for Support of Biomedical Research (Executive Council Agenda-----p. 46)	

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

MINUTES

Thursday, June 30, 1983
9:00 am - 1:00 pm
Dupont Room
Washington Hilton Hotel
Washington, D.C.

PRESENT

(Board Members)

Arnold L. Brown, M.D.
D. Kay Clawson, M.D.
William B. Deal, M.D.
Ephraim Friedman, M.D.
Fairfield Goodale, M.D.
Richard Janeway, M.D.
William H. Luginbuhl, M.D.
Richard H. Moy, M.D.
M. Roy Schwarz, M.D.
Edward J. Stemmler, M.D.

(Staff)

James Bentley, Ph.D.
Janet Bickel
Robert Boerner, Ph.D.
John A.D. Cooper, M.D.
Debra Day
John Deufel
Charles Fentress
Sandra Garrett, Ph.D.
Paul Jolly, Ph.D.
Thomas J. Kennedy, Jr., M.D.
Joseph A. Keyes, Jr.
Anne Scanley
James R. Schofield, M.D.
John F. Sherman, Ph.D.
Emanuel Suter, M.D.
Kathleen Turner

(Guests)

Steven C. Beering, M.D.
Pamelyn Close
Robert Heyssel, M.D.
Robert Keimowitz, M.D.
Manson Meads, M.D.
Thomas K. Oliver, Jr., M.D.
Ed Schwager

I. Call to Order

The meeting was called to order at 9:05 am.

II. Report of the Chairman

Due to the lengthy agenda, Dr. Janeway did not present a Chairman's Report.

III. Approval of the Minutes

The minutes of the April 21, 1983 meeting of the Administrative Board were approved without correction.

IV. Action Items

A. Plan of Action for Dealing with PGY-2 Match Issues

At the April meeting of the Executive Council, staff was requested to study the issues related to the selection of residents for PGY-2 positions and to prepare a "recommended course of action" for dealing with the problems identified.

Since that time, Dr. Cooper has written to the presidents of 18 societies and associations of program directors. He solicited their cooperation and asked three questions: whether their society had an official policy regarding the match; whether the society was satisfied with the current situation; and whether there was any reason to believe that NRMP was incapable of handling their concerns. Ten responses had been received at the time of the meeting.

Dr. Keimowitz, Chairman of the Group on Student Affairs, expressed the group's interest in the subject and its willingness to provide assistance. Toward that end, the GSA had agreed to develop a white paper which would discuss its perception of the nature and causes of the current situation.

The Board discussed issues relating to technical capabilities of the NRMP. Dr. Cooper assured the members that the computer technology was in place and functioning effectively. Student skepticism regarding the match as being in their own best interest was mentioned by staff and confirmed by Ed Schwager. The Board attempted to assure the students that the match program was much more desirable than the chaos that had preceded it and which inevitably would follow.

On motion, seconded and carried, the Board endorsed the staff's recommended plan of action for dealing with PGY-2 match issues, namely, that the AAMC continue to involve the parties with interests at stake in this matter in discussions about the nature and scope of the problems; that an analytic summary of the responses to Dr. Cooper's letter be prepared; that a problem list and mechanisms for addressing the problems be developed including consideration of incentive for compliance and sanctions for noncompliance; and that the staff in consultation with the leadership of the Councils and the OSR, selected program directors, and the staff of the NRMP develop a set of recommendations which could win the endorsement of

the AAMC, the NRMP and preponderance of the program directors in the troublesome specialties for consideration by each of these groups in the fall and at the AAMC Annual Meeting.

B. ECFMG Constitutional Issues

At the January, 1983 meeting, the Executive Council reviewed the proposed "Protocol for the Recognition of State Medical Societies to accredit Interstate CME sponsors." At that time, the Council disapproved the proposed ACCME protocol and stipulated that Section II, Methodology be modified to require that:

Three members be selected from nominations made by the ACCME member organizations, in addition to the seven members selected from nominees to sit on the CRR;

The chairperson of the CRR transmit the recognition decision of the CRR to the ACCME for review and acceptance.

Dr. Suter stated that at a subsequent meeting of the ACCME, the Committee revised the protocol to comply with the Council's first recommendation that the ACCME be represented on the CRR, but limited the number of representatives to two. Dr. Suter reported that the ACCME did not accept the Council's second recommendation that the ACCME retain the right to accept or reject a decision by the CRR.

After discussion, the Board moved to accept the first compromise, i.e., the selection of three representatives, but rejected the second revision and chose to insist that the ACCME retain the right to review and reject CRR recommendations.

C. Loan Forgiveness for Physicians in Research Centers

Dr. Oliver reviewed the proposal for Loan Forgiveness and stressed that those faculty who would be eligible, 1) would have at least two years of research training beyond the core of their residency program; and 2) would have been recruited by institutions into tenure track positions at the level of assistant professor.

A lengthy discussion ensued concerning the basic premise that M.D.'s do not enter into research because of their loan indebtedness. Some suggested that this result may occur because of the type of candidate that is accepted into medical school and the nature of research itself; rather than financial indebtedness. Concerns about the mechanism advanced for inducing more MD's into research included: the equity in forgiving only federal loans; the possibility of forgiving interest payments only; and the feasibility of obtaining federal support for the overall program. While the Board was in full agreement with the objective that the proposal sought to achieve, it was uneasy with the mechanism selected. Noting that the objective was also given high priority by the Director of NIH, Dr. Wyngaarden, the Board recommended that the AAMC maintain close contact with the NIH and support the strategy which it regards as most feasible.

D. Faculty Employment Policies and Practices

John Deufel described the events that occurred in stimulating the development of the survey and stated that the Group on Business Affairs requested that a directory be published that would network managers who were currently facing similar personnel issues.

Because of this long-standing interest in tenure-related issues, the Department of Institutional Development had collaborated in the development of the survey. The staff proposed that the survey be simultaneously mailed to both the Dean and the Business Officer. Several of the Board members suggested clarification of some items, but generally endorsed the survey as potentially useful. Further discussion focused on the applicability of the AAMC's data release policy, which classified data as unrestricted, restricted, and confidential.

On motion, seconded and carried, the Board endorsed the survey and agreed to send comments, suggested revisions and recommend action regarding the proper data classification of particular data elements to Mr. Keyes within two weeks.

E. Consultant File

Mr. Keyes reported the staff proposed to respond to a suggestion made by the Planning Committee of the Association's Management Education Program, by establishing a Consultant File. The purpose would be to have reference available to institutions seeking to learn what the experience of other institutions had been with regard to the use of consultants for dealing with issues arising at academic medical centers.

Discussion ensued regarding the appropriateness of including both positive and negative assessments of consultants' performance.

On motion, seconded and carried, the Board moved to endorse the concept of a Consultant File, but recommended the elimination of evaluative references to consultants' performances in the request for information on consultants.

F. Distinguished Service Members Nomination

Dr. Janeway recommended that a committee be appointed and chaired by Dr. Roy Schwarz, Dean, University of Colorado School of Medicine with Dr. Louis Kettel, Dean, University of Arizona College of Medicine, and Dr. Arnold Brown, Dean, University of Wisconsin Medical School.

On motion, seconded and carried, the Board approved this Committee.

G. The Status of the Management of Student Financial Assistance at U.S. Medical Schools

Mr. Keyes stated that last year the Board had proposed that a Task Force be established to examine non-governmental sources of capital to fund financial aid programs. After review, the advice received by the Association was that it should not involve itself in a visible, national effort to develop alternative funding sources, but rather, maintain pressure on the Federal government to provide such support. Because of the importance of the financial aid issue, the AAMC was continuously alert to opportunities to provide a useful service in this area. Staff solicited the Board's advice regarding the potential utility of a workshop series for Admissions Workshops financial aid officers, modeled in part on the Simulated Minority of the Association's Division of Student Programs, submitted a proposal for the development and presentation of several regional workshops to explore additional financial aid issues.

Several members expressed skepticism regarding the need for such workshops.

On motion, seconded and carried, the Board deferred endorsement of the proposal and agreed to discuss the need for such workshops with their own financial aid offices prior to the next Board meeting.

H. Payment for Physician Services in a Teaching Setting

Dr. Knapp, Director, Department of Teaching Hospitals, reported to the Board that the AAMC's Committee on Payment for Physician Services in Teaching Hospitals met: 1) to review final Medicare regulations on payment for physician services and hospitals; and 2) to discuss potential Association responses to the planned special regulations for physicians in teaching hospitals. In considering the options set forth in its report. The Committee leaned toward Options 3 and 6, i.e., we should argue that low medicare payments be excluded and seek to amend Section 948. In discussing these options, Dr. Knapp argued that because Section 948 did some important things for us it would be unwise to seek its complete repeal; if possible, we should seek to modify the fee determined portion with such language so that it could be construed that Medicare fees in teaching hospitals would be based solely on reasonable, customary, and prevailing charges made to Medicare beneficiaries. Arguing that low medicare payments be excluded from the calculations by administrative action would be more tenuous. This is because the HHS Secretary must approve the payments under the plan as reasonable for Medicaid plans to receive federal financial participation. To avoid having low Medicaid payments reduce Medicare payments, the Association would need to argue that Medicaid fees are unreasonable. This argument would obviously place the Secretary in an awkward position. Amendment of Section 948 on the other hand, would require Congressional action. This always creates the risk that Congress would amend the proposal placed before it and pass something considered unacceptable by the AAMC.

Lengthy discussion pursued regarding the appropriate course of action for the Association to take. Several schools most adversely affected had already initiated Congressional consideration of the

problem. The Board recommended that the AAMC play a supportive rather than a leadership role in the effort of these schools seeking legislative relief.

On motion, seconded and carried, the Board approved the staff's recommendations and placed reliance on the staff's discretion in future communications with Congressional staff.

I. Counting Residents for the Medicare Prospective Payment System

Dr. Bentley, Associate Director, Department of Teaching Hospitals, described the two payment component included under the rubric of medical education in the Medicare Prospective Payment System: 1) payment for the direct cost of education including, stipends of houseofficers, faculty salaries, etc.; and 2) the "indirect cost of medical education": adjustments in the hospital payment amount that is calculated on the ratio of the number of residents to the number of hospital beds. He stated that since the adjustment provides a 12.13% increase in per case payment for 0.1 residents per bed, the specifications regarding how Medicare is proposing to count residents are critical.

Dr. Bentley reviewed what we understand to be the likely Medicare methodology for counting residents. He described what he regarded as the major weaknesses, and identified a series of unique situations that defy the proposed methodology. The staff recommended that: 1) staff meet with HCFA and Congressional staff to describe the weaknesses, and 2) to urge them to adopt an alternative based on the premise that the number of FTE residents be determined from the residents assigned, with one full-time equivalent equal to twelve man-months of training in the hospital.

The staff recommendation was based on the perception that silence now, and members exploitation of the HCFA approach would lead to payments based on numbers of residents in excess of the actual total number. A hospital management consideration was addressed. The HCFA proposal could lead program directors to seek payment for fellows. On the other hand, the "indirect cost of medical education" component is really a surrogate for hospital case mix intensity and the inclusion of fellows would accurately reflect more intense institutions. The Board decided to await the advice of the COTH and deferred action on the item until the Executive Council meeting.

V. Discussion Items

A. Statement of Principles on NIH

At the April meeting, the Administrative Boards and the Executive Council discussed pending authorization proposals for the NIH and decided that the Association would not support any of the bills because they violated the basic principles held by the Association. The Council requested staff to develop a Statement of Principles that could be used as a basis for generating public support for the NIH and the continuation of its present organizational structure.

In developing the document, the staff determined that at a minimum, two different audiences would need to be addressed: 1) medical school faculties, and 2) policy makers. There were two documents prepared.

The Board agreed that both documents represented excellent first responses to the Council's request. It concluded that the next step would be to develop a strategy paper outlining a coordinated program for the long-term action. The plan should include consideration of methods for communicating with the faculties and the special interest groups. The strategies plan should be developed over the summer and presented to the Boards for their review at the September meeting.

B. Trends in Graduate Medical Education Positions

Time did not allow for discussion of this issue.

C. 1983 AAMC Annual Meeting/COD Program

The consensus of the Board was to reduce the time spent in the business meeting and to invite a speaker such as Dr. Luginbuhl to deliver his presentation on cost containment. This type of session would enable the deans to both conduct a formal business session and engage in a dialogue on a topic of interest and concern.

D. 1984 COD Spring Meeting Topic

Time did not permit for discussion of this issue.

E. 1985 COD Spring Meeting Date

Approved.

VI. OSR Report

A. Contribution of Housestaff to AAMC

Ed Schwager stated that the role of housestaff in the AAMC has been of concern to the OSR since its inception ten years ago. Speaking for the OSR, he believes that the housestaff occupy a unique position in the continuum of graduate medical education and that many of the issues discussed at the Councils directly affect the housestaff. The OSR requested the Boards' reaction to their proposal and if advisable, asked for further assistance in developing a mechanism to integrate the housestaff into AAMC activities.

Board members generally regarded appropriate involvement of houseofficers as a desirable goal and considered methods of accomplishing this short of establishing a new formal organizational relationship, e.g., attendance at the annual meeting. Because of

the limited time and the relevance of the issue to the other Councils of the AAMC, the Board adopted Dr. Janeway's suggestion that the matter be referred to the Executive Committee.

VII. Adjournment

The meeting was adjourned at 1:00 pm.

ELECTION OF DISTINGUISHED SERVICE MEMBERS

At the June COD Administrative Board meeting, Dr. Janeway appointed the following to serve on the Distinguished Service Member nominating committee: M. Roy Schwarz, M.D., Chairman, Arnold L. Brown, M.D., and Louis J. Kettel, M.D. This committee solicited recommendations from the general membership of the Council of Deans. Recommendations were received and the committee met prior to the Administrative Board meeting. Their report will be presented to the Board at this meeting.

COMMERCIAL SUPPORT OF
CONTINUING MEDICAL EDUCATION

In a recent communication to Dr. Cooper, Richard S. Wilbur, as Secretary of the ACCME, expressed concern that some medical schools may inappropriately co-sponsor CME activities supported by pharmaceutical companies and/or equipment manufacturers. His communication included copies of two policy statements regarding the relationship of accredited CME sponsors and commercial companies (see letter and enclosures, attached). Dr. Wilbur conveyed a ACCME request that AAMC Executive Council review these statements and consider developing an AAMC policy statement addressing this issue.

This matter is brought to the Council of Deans Administrative Board for its advice. Support of CME from commercial enterprises raises several issues and questions. The first is a general question, namely to what extent the flow of money from the commercial sector into CME may influence utilization of drugs, instruments, and accompanying procedures by physicians and patients. The answer is not readily available but advertising firms and market analyzers probably could show affirmative evidence of qualitative if not quantitative nature. On the basis of ethical or moral principles institutions or organizations may want to establish policies aimed at excluding any potential erosion of the educational integrity of the institution through commercial grants or other support of CME programs.

A second question addresses the conditions under which a CME program can receive partial or total support from a commercial source, or a CME sponsor can co-sponsor a program offered by a commercial organization without violating the principles of academic freedom and fair presentation of scientific facts. Dr. Wilbur's communication is directed at this level of concern. The most common interest of a commercial enterprise obviously is to buy exposure of a product or the firm's name in connection with diagnostic or therapeutic problems. The offense, if any, to unbiased education may be very subtle or it may be quite blatant. Many institutions and organizations have established internal policies to regulate the acceptance of financial support for CME programs from a commercial donor. Among them are medical schools (see e.g. the policy of the University of Nebraska asking Medical Center policy, attached), the American College of Physicians (attached) and others. Most of these policies specify the conditions under which continuing education programs may accept funding from commercial sources. Some of these conditions are that (1) the funds be received by the institution and used in accordance with institutional policies; (2) the CME unit retain undisputed control over program planning and execution, including topics and speakers for the presentations and the final evaluation of the program; (3) the utilization of funds be specified in advance; (4) the recognition of the grants be limited to brief statements on the activity programs without display of products or services available from the grantor; and (5) products of a donor not be mentioned unless pertinent alternatives to those products are also presented so that any suspicion of endorsement of a product be avoided.

Similar policies and procedures prevail for co-sponsorship by an accredited institution of continuing education courses or materials presented or distributed by a commercial company.

Finally, a third level of concern addresses the potential detrimental effect of moneys for CME from commercial firms on the internal functioning of CME within the institution. CME directors are particularly concerned over donations from firms to individuals or individual departments by-passing the continuing medical education unit of the institution. Another disturbing problem for some institutions is the fact that some of their faculty are lured into participating in commercially sponsored programs offered by other organizations, for instance hospitals, specialty societies, travel firms, that pay relatively generous honoraria to faculty which cannot be matched by the home institution, therefore making it more difficult for the CE provider unit of the institution to attract faculty for their own programs.

Recommendation

- That the Administrative Board of the COD review some of these issues.
- That the Group on Medical Education be asked to review these questions and to develop a recommendation regarding an appropriate stance for the AAMC.
- That the COD Administrative Board provide the CME with such advice, guidance or observations as it deems appropriate.



Accreditation Council for Continuing Medical Education

P.O. Box 245 Lake Bluff, Ill. 60044 (312) 295-1490

August 12, 1983

John A. D. Cooper, M.D.
President
Association of American
Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, DC 20046

Dear John:

The ACCME has expressed growing concern over what appears to be inappropriate co-sponsorship by some medical schools of CME activities supported by pharmaceutical companies and/or equipment manufacturers. This places the medical school in the position of appearing to recommend a particular product to the physician audience, thereby adversely affecting its credibility as a sponsor of continuing medical education. Enclosed are two statements addressing this question which the ACCME requests the Executive Council to review, with the hope that the AAMC might consider approving some similar statement.

With kindest personal regards.

Yours cordially,

Richard S. Wilbur, M.D.
Secretary, ACCME

CC: Patrick J. V. Corcoran, M.D.
Richard M. Caplan, M.D.
John N. Lein, M.D.
Henry P. Russe, M.D.

RSW/kf

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American Board of Medical Specialties
One American Plaza, Suite 805
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 for Hospital Medical Education
1101 Connecticut Avenue, N.W.
Washington, D.C. 20036

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

Federation of State Medical Boards of the U.S., Inc.
2630 West Freeway, Suite 138
Fort Worth, Tx. 76102

Approved May, 1983

THE RELATIONSHIP BETWEEN COMMERCIAL COMPANIES AND
CME COURSES PRESENTED BY MEDICAL SCHOOLS

It is widely recognized that financial relationships between commercial companies (pharmaceutical, equipment, publishing, etc.) and medical schools have been increasing in the past few years. The potential for mutually beneficial results from these cooperative arrangements in both research and education is excellent. Consequently, these cooperative efforts should be encouraged. However, each medical school must be careful that it does not engage in an activity that is (or appears to be) inconsistent with its academic integrity. In addition, lapses by a medical school in maintaining appropriate standards may also damage the general reputation of other medical schools.

The recently increasing cooperative efforts in continuing medical education between commercial companies and medical schools are producing highly beneficial results for the companies, for the medical schools, and for course enrollees in many instances. At the same time, the causes for genuine concerns are becoming more obvious. It is recommended that medical schools use the following guidelines:

- 1) Medical schools should not present or cosponsor a continuing education course concentrating on products of a commercial company that is providing financial support for that course unless the pertinent alternatives to those products are also presented.
- 2) Medical schools should exert substantial caution before presenting or cosponsoring a continuing education course that is planned and/or implemented through a media organization employed by a commercial company.
- 3) Medical schools should exert substantial caution before agreeing to sponsor or cosponsor a continuing education course that is distributed by a commercial company. If the course is a correspondence course utilizing only bound books, the consistency

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of the content can be more assured than in those instances when "live" discussions are included.

- 4) All money from commercial companies to support CME courses presented by medical schools should be paid to the respective school and handled in accordance with institutional policies.

As stated previously, cooperative efforts between commercial companies and medical schools should be encouraged and increased for the mutual benefit of the companies and the schools. The preceding guidelines are designed to maintain and enhance the credibility and reputations of both the commercial companies and the medical schools.



The Canadian Medical Association

L'Association médicale canadienne

Guidelines for Acceptance of Pharmaceutical Company Financing of Continuing Medical Education Courses and Meetings

Preamble

The need for continuing medical education at all levels of practice is well recognized. Funding of continuing medical education has been helped significantly over the years by generous contributions from pharmaceutical companies. The CMA acknowledges and appreciates this financial support. Observation of a few guidelines, founded on basic principles, is vital if this valuable funding source is to be preserved.

1. The organization, content and choice of speakers must be determined by the physician organizers. The organizers may be CME directors at medical schools, CME physician organizers in community hospitals, or CME representatives for specialty and professional societies.
2. Disposal of funds should be the responsibility of the physician organizers. While the program should acknowledge the financial aid received, it should not designate the sponsor's product. It is appropriate to acknowledge the assistance of the sponsoring pharmaceutical company.
3. As a principle, the use of generic names is preferred in presentations and discussions.
4. Large scientific congresses frequently attract commercial exhibits of pharmaceutical companies. If this is the case, and it coincides with a CME session, negotiations for space or display should be conducted separately from discussions for CME sponsorship.
5. The value of social functions at CME meetings is recognized. However, they should neither compete with, nor take precedence over, central events.

Approved by the CMA Board of Directors
March 5, 1983

Subcommittee on Continuing Medical Education
College of Medicine
University of Nebraska Medical Center

Program Relationships with Pharmaceutical Manufacturers

Introduction:

Recognizing that pharmaceutical manufacturers and similar companies provide support for continuing education programs in a variety of ways, e.g., direct financial support, exhibits, speakers, and materials, these guidelines outline an appropriate relationship between the College and such companies for continuing medical education programs which are sponsored or co-sponsored by the College and/or a department within the College.

Guidelines:

1. Program Control - Overall responsibility for the program is vested in the College through the course chairman. This includes all aspects of the planning and selection or approval of speakers, topics and meeting sites.
2. Faculty Selection and Accommodations - Invitations to speakers, and arrangements for travel and lodging are the responsibility of the College.
3. Honoraria - Any honoraria to be paid to program faculty must meet the guidelines of UNMC and the College. Exceptions to this should be approved by the Subcommittee on CME.
4. Financial - The payment of all funds from a pharmaceutical firm should be in the form of an educational grant and made payable to UNMC or the University Foundation for the support of the program. If funds remain after a course is completed, they will be distributed in a manner determined in advance of the course.
5. Displays and Materials Distribution - Booths, exhibits, or other displays may be set up in a manner approved by the Associate Dean and the Director of Continuing Education. Materials distributed by the company such as monographs or articles should be educational in nature rather than promotional of the company's products.
6. Representatives - Pharmaceutical company representatives may be invited to attend educational programs but should make their presence unobtrusive and non-promotional.
7. Publicity - Publicity for the program should be controlled by the College and Center for Continuing Education. Pharmaceutical representatives may be asked to assist in this at the discretion of the program chairman. Recognition of support for the program may be listed in the brochure and handout materials.
8. Materials - The handout materials may not contain promotional material from the pharmaceutical company but support for the program may be acknowledged on the brochure and in the handouts.
9. C.E. Credit - All credit approvals and recording will be handled by the College and the Center for Continuing Education in the normal manner.



American College of Physicians

4200 Pine Street
Philadelphia, PA 19104
(215) 243-1200
(800) 523-1546
TWX 710 670 0586

Robert H. Moser, MD, FACP

Executive Vice President

John R. Ball, MD, JD

Associate Executive Vice President
Health and Public Policy

Suzanne Stone

Assistant Director
Planning and Operations
Department, Health and Public Policy

1 September 1983

Ms. Kat Turner
AAMC
1 Dupont Circle #200
Washington, DC 20036

Dear Ms. Turner:

In researching your question from our phone call yesterday, I found that Dr. Beering's memory served him well, and that we do indeed have a policy on CME funding by pharmaceutical firms. It is a policy of the Board of Regents, and is attached.

I'm sorry for its informal look, but I had to lift it from a lengthy document.

I hope you find it useful.

Sincerely,

Nancy Magargal
Research Assistant

enclosure

6. Pharmaceutical Industry Support Policy

Educational grants from pharmaceutical and other commercial companies for programmatic support are appropriate for Regional Meetings when these awards conform to the following guidelines:

- a) Educational grants must be for specific educational activities (e.g., travel of speakers, honoraria, audiovisual expenses, auditorium rental, staff support, printing, buses, and coffee service for sessions and/or exhibitors).
 - b) The appropriate Chapter Committee will have final authority on all matters. Grantor may offer recommendations regarding format, content, and speakers for scientific events.
 - c) No product advertisements are allowable in conjunction with grant support of specific program features. Recognition of such grants shall be through institutional announcements, as follows: "This program is supported (in part) by an educational grant from _____."
- Product advertising in the printed advance and/or final programs of the Annual Session may be accepted for financial support of program printing costs, only. Pharmaceutical industry support of scientific program features will also be noted in the final program.
- d) Direct support for social events is not permissible. Grant support for the total program may be used as deemed appropriate by the program director.

AAMC REGIONAL BOUNDARIES

The Association is currently divided into four regions (see attached map). Although the Association's by-laws refer to the regions, they do not define them. The regions of the Association come into consideration on two occasions.

Governance: The by-laws require that "at least one elected member of the Executive Council shall be from each of the regions of the Association." The by-laws of the Council of Deans require that "due regard for regional representation" be given in the nomination and election of officers for the Administrative Board. Neither CAS nor COTH have regional requirements.

Regional Meetings: The Association is involved in two kinds of regional meetings. The first occurs on an ad hoc basis when a series of workshops are presented sequentially, usually to minimize transportation costs for participants. Recent examples are the special seminars on the prospective payment system in June and July and the 1982 Regional Institutes on Geriatrics and Medical Education. On these occasions it is useful for planning and budgeting purposes to have a fairly even distribution among the four seminar sites.

Three of the five groups of the Association (Group on Student Affairs, Group on Medical Education, and Group on Public Affairs) hold regional meetings. In the Group on Business Affairs, only the southern schools meet as a region. No regional meetings are held by the Group on Institutional Planning. For the Councils, only some of the COD groups meeting regionally, including the southern deans and the midwest or central deans.

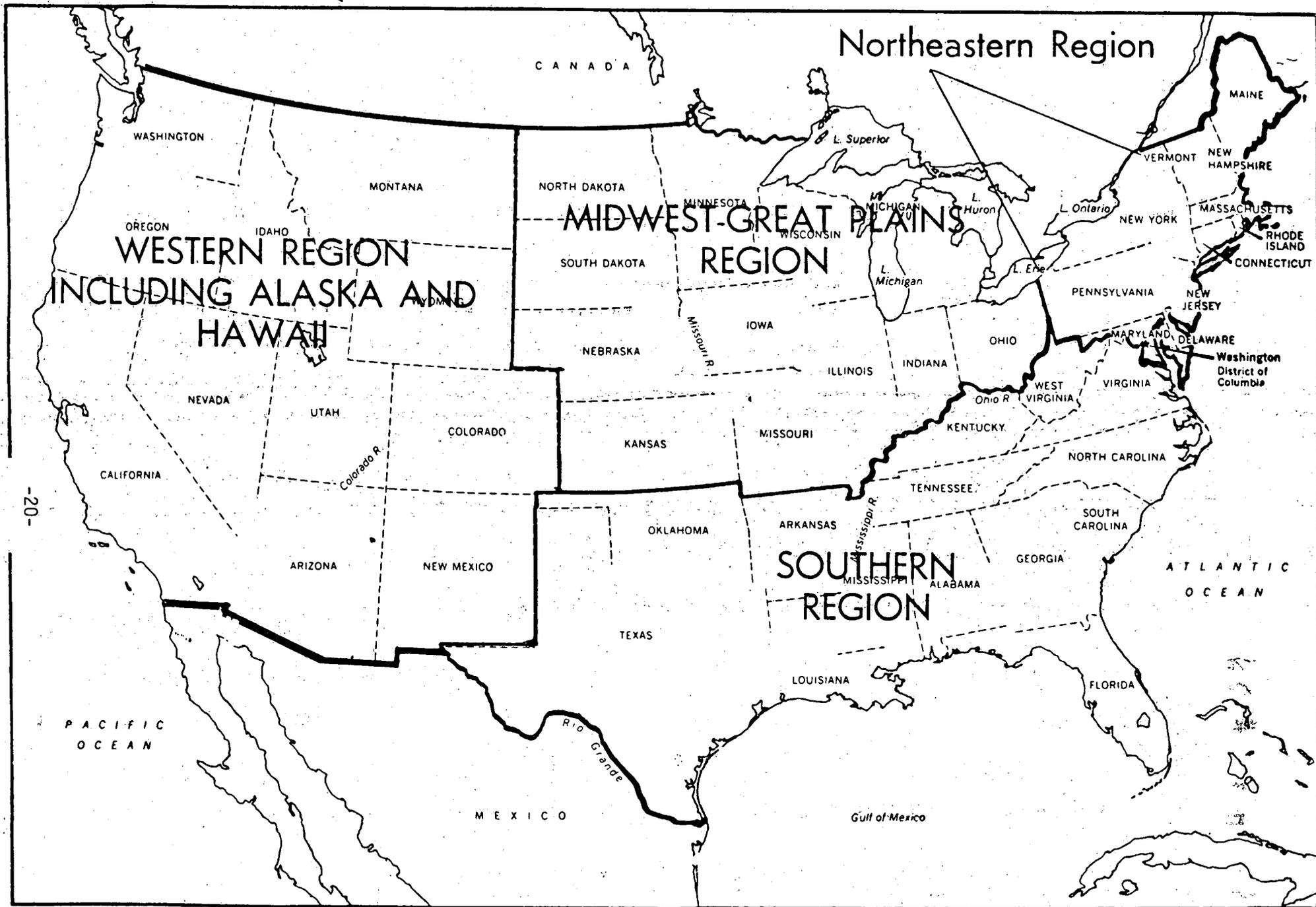
As you can see, the current regions do not have an even distribution of medical schools:

Northeast	36
Midwest/Central	32
Southern	42
Western	16

The Group on Public Affairs has changed its boundaries to include the seven Texas schools in the western region to provide a more even distribution, to provide more equitable access to leadership opportunities, and to strengthen the programmatic offerings of the western regional sessions.

Question for Discussion:

Should the Association consider realigning its regional boundaries?



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MEDICAL CENTER OFFICIALS AND THE AAMC

From time to time the Association hears from individuals in the academic health center (other than the medical school dean) who would like to be more involved in AAMC activities. These individuals are usually vice presidents for health affairs or presidents of medical centers. The requests are frequently related to the AAMC's communications network (e.g., "pink" memoranda), but also include vague comments about wanting to "be involved" in AAMC activities.

Some deans apparently circulate some, but not all, pink memos, and this had led to requests from other medical center officials to be included on the AAMC mailing list. Several years ago the Executive Committee authorized the circulation of selected pink memos on legislative and regulatory issues to members of the Association of Academic Health Centers. This had been fairly successful in reducing such inquiries, but recently similar requests have come from individuals who are not AAHC members. Because of the varying organizational patterns at medical centers, it is hard to identify by title alone all such administrators who might be interested in AAMC memos. Further, the Association has always taken the position that its communications are sent to the institutional representative (dean) only, and a general mailing list is not maintained.

There is no channel for these individuals to be active in the Association unless they are distinguished service members (in which case they are invited to spring council meetings and receive publications, but not pink memos) or serve on an AAMC committee (very rare).

It appears to Association staff that in many academic medical centers individuals other than the dean and hospital administrator are acquiring substantial authority and responsibility for decisions impacting on medical education. This is particularly true with respect to financing issues and the operation of patient care services. If there is a power shift occurring at medical centers, the Association should be considering how this impacts on its membership and its own position as spokesman for academic medicine. This will be a topic at the December officers' retreat, but staff wished to elicit comment from the Administrative Boards which could be incorporated into the background paper for that discussion.

Questions for Discussion

1. Should the Association consider expanding its communications network? If so, on what issues and how should recipients be identified?
2. Is there some kind of participatory role that can be identified for officials who hold positions above or equal to the dean or hospital administrator in the medical center hierarchy?
3. Is the AAMC-AAHC relationship basically competitive or can it be cooperative? What are our options under each mode?

ENROLLMENT OF STUDENTS IN SUMMER COURSES

By the attached letter, Dr. Luginbuhl suggests that the AAMC should consider the matter of member medical schools enrolling students from foreign medical schools in summer courses. He does not suggest an AAMC position but does suggest that a reasonable first step would be the collection of data on current practices. On the basis of this suggestion the Division of Student Programs made some inquiries and reports the following:

Each spring the Division of Student Programs sends a memorandum to student affairs deans requesting information on summer make-up courses the school may be offering that year. The schedules received are then compiled and sent to deans to assist them in counseling students and in responding to requests for such information. The AAMC memorandum requests that: "the schedule contain only those make-up or special courses which enable medical students to fulfill the requirements for advancement with a particular class". For the summer of 1983, 20 U.S. schools mailed to the AAMC a copy of their schedules, up from 13 in 1982 (Attachment A is the cover page of the compendium).

Staff recently attempted to contact course directors to ascertain whether these schools enrolled students from foreign medical schools this summer. Course directors at twelve schools were spoken with. Only one (Vermont) has a policy that participating students must be enrolled in an accredited U.S., Puerto Rican or Canadian school. One faculty member noted that students who have not taken the course before are routinely excluded. All but one of the twelve persons queried were familiar with the origins of the students enrolled in their courses. When asked whether they had received inquiries from students enrolled in foreign medical schools, three answered 'no'. From the remaining course directors, the most frequent answer was "two or three"; no one said more than 'five'. The most frequently mentioned foreign school was St. George's; students from Grenada, Mexico and Ireland were also heard from. The number of such inquiries does not appear to be increasing; in fact many received more in 1982 than in 1983. Hahnemann was the only school at which a course director reported enrolling a student from a foreign school this past summer.

Overall, it can be stated that schools have not recognized a need for a policy to keep students from foreign schools out of their make-up courses. Some faculty noted that offering these courses is a departmental money-garnering venture; -- the mean tuition was \$912 (range: \$235 - \$1931). In general course directors admit a willingness to enroll all students who meet the stated qualifications, which are usually limited to approval letter from the student's dean or department chairman (in addition to course prerequisites).



association of american medical colleges

MEDICAL SCHOOL SUMMER MAKEUP COURSES, 1983

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The University of Vermont

COLLEGE OF MEDICINE, OFFICE OF THE DEAN
GIVEN BUILDING, BURLINGTON, VERMONT 05401
TEL. (802) 656-2150



July 5, 1983

Mr. Joseph A. Keyes
Director
Department of Institutional
Development
Association of American Medical
Colleges
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear Joe:

This letter is written in follow-up to our brief discussion about enrollment policies in summer courses. Our Chairman of Pharmacology tells me that other institutions are enrolling students from foreign medical schools, including Carribean schools. I am not certain what the AAMC position on this should be, but I do think it is something that we should consider. Perhaps a reasonable first step would be the collection of data on current practices.

I trust the copies of my slides were satisfactory. I will be glad to consult by telephone if there are questions about them.

Sincerely,

A handwritten signature in cursive script that reads "Bill".

William H. Luginbuhl, M.D.
Dean

WHL:cb

EVALUATION OF THE STATUS
OF THE MANAGEMENT OF STUDENT FINANCIAL ASSISTANCE
AT SELECTED U.S. MEDICAL SCHOOLS

The agenda for the June meeting of the Council of Deans Administrative Board included a request for advice about the need for a series of workshops to improve the administration of student financial assistance to medical students. The recent expansion of the role of financial aid officers at many schools was described. These duties now range from the awarding of aid to raising aid funds, teaching financial management to students and collecting loans. The increasing complexity of student aid programs; the reported 20 percent annual turnover of individuals having primary responsibility for student assistance; and the Health Professions Student Loans collection rate (only approximately one-third of the schools evidenced the ability to meet the proposed federal collection standards for that program in June 1982), were suggested as possible indicators of a need for AAMC involvement. Board members were unconvinced of a need and suggested that, prior to the September meeting, members assess the situation at their own institutions to determine whether a workshop series might profitably address current concerns. Attached are an evaluation checklist and information on student indebtedness provided as references to assist this assessment.

Question for Discussion:

1. Does the assessment of the preparation of the financial aid staff indicate that a workshop is a potentially profitable activity for the AAMC to conduct?
2. Is there any other initiative in the area of student financial assistance that the AAMC should undertake?

EVALUATION CHECKLIST FOR FINANCIAL AID STAFF

Does the financial aid staff feel that their backgrounds and training are adequate to carry out the following responsibilities? Are they able to:

1. Provide adequate personal financial counseling to enrolled students.
2. Provide financial information and counseling to prospective students.
3. Maintain a good student assistance records system.
4. Collect student loans effectively i.e., keep delinquencies in the Health Professions Student Loan Program below 5 percent.
5. Exceed the standards of federal auditors.
6. Satisfy the students regarding the availability and administration of student aid.
7. Maintain the availability of scholarship and/or low interest loan funds.
8. Locate new sources of student assistance.
9. Create new sources of student assistance.
10. Teach students financial planning and management utilizing written materials and/or local or imported experts.
11. Teach students debt management by informing them each time they borrow of their total indebtedness, giving them individualized terms and repayment schedules for each loan, making them aware of income tax strategies, demonstrating the implications of their repayment obligations during residency and throughout the life of each loan.

INDEBTEDNESS OF GRADUATING MEDICAL STUDENTS REPORTING DEBT*

YEAR	PERCENT OF SENIORS REPORTING INDEBTEDNESS	AVERAGE INDEBTEDNESS	PERCENT CHANGE FROM PREVIOUS YEAR
1978	76	13,800	
1979	76	15,800	+14.5
1980	77	17,200	+ 8.9
1981	76	19,700	+14.5
1982	83	21,100	+ 7.1
1983	86	23,600	+11.8

*SOURCE: AAMC Graduation Questionnaire

Twenty-five percent of 1983 graduates reported indebtedness of \$30,000 or more.



association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

September 6, 1983

202: 828-0460

Ms. Betty Lou Dotson
Director
Office of Civil Rights
Department of Health and Human Resources
330 Independence Avenue, S. W., Rm. 5400
Washington, D. C. 20201

RE Proposed Rule: Nondiscrimination on the Basis of Handicap
Relating to Health Care for Handicapped Infants

Dear Ms. Dotson:

On behalf of the members of the Association of American Medical Colleges, I am writing to express our grave displeasure with the revised version of the regulation addressing the provision of health care to handicapped infants published on July 5, 1983. A federal district court judge nullified the original regulation, calling it "arbitrary and capricious" and "a hasty and ill considered (method of addressing) one of the most difficult and sensitive medical and ethical problems facing our society." After such an admonishment, it is distressing to find that the Department of Health and Human Services could reissue the regulations virtually unchanged. The implication in the regulation, particularly in the preamble, that health care providers callously allow handicapped children to die from lack of treatment or nutrition is offensive to all health care providers and particularly to those who have devoted their professional lives to caring for sick children.

Just a few decades ago, most sick newborns died within a few hours of birth and premature infants were not expected to live more than a few days. Through the efforts of many health care professionals, the prognosis for these infants has changed radically. The many technological advances and the new skills in neonatology substantially have reduced the mortality rate for the severely ill and premature infants. In fact, since 1970 infant mortalities have been halved.

It is ironic that the professionals that make it possible for infants with critical problems to have a chance at life are treated in a proposed federal regulation as if they would habitually disregard a handicapped infant's needs. This assumption is false. Hospitals and their medical staffs provide care for all patients to the best of their ability. Teaching hospitals have a particular commitment to patients in need of critical care, including the infants that are the subject of this regulation. At the 350 nonfederal teaching hospital members of the AAMC, there were more than 720,000 births in 1980. More than three-quarters of these teaching hospitals provide premature nurseries and more than 70 percent have neonatal intensive care units.

Additionally, teaching hospitals and the medical schools with which they are associated train new physicians and engage in new areas of research to perpetuate and enhance their ability to care for critically ill infants.

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Ms. Betty Lou Dotson

September 6, 1983

Traditionally, the parents and the physicians have made the very difficult decisions regarding the treatment that should or should not be rendered to children with life-threatening conditions. While some may disagree with the choice made in some of the cases, it should be recognized that the parents and physicians believed themselves to be acting in best interests of the child. The questioned raised by the case of Infant Doe and the resultant public outcry is how can the public voice its opinion regarding what is in the best interests of the child, presuming that this public voice would be less likely to concern itself with any physical or mental handicap of the child, or with the costliness of rendering continuous treatments to a child so handicapped.

The Department of Health and Human Services' answer to this question is that there ought to be an "alarm system" comprised of posted notices and toll free hot lines by which anonymous tipsters can summon teams of representatives from state child protection agencies and/or the Office of Civil Rights. This proposed approach is seriously flawed for several reasons:

- In the event there is a case in which a child is wrongfully denied treatment or nutrition, the HHS approach provides no assurance that the authorities would be called in time to take steps to protect the child.
- It is highly likely that this approach will result in a number of hospitals and physicians being falsely accused of inappropriately withholding treatment or nutrition. The few weeks in which the first "Baby Doe" regulation of the Department was in effect provided ample evidence that such false accusations would occur. These false accusations can be made either by well intentioned but uninformed people or by crank callers who may seek to harass the institutions or physicians involved.
- Perhaps the most disturbing consequence of the Department's proposed rule is the affect this method has on other infants. For example, during the period in which the original rule was in effect, an investigation was made on a "hot line" tip that Siamese twins at Strong Memorial Hospital in Rochester, New York were not receiving adequate care. This tip prompted the Office of Civil Rights to intercede. While everything possible had been done for the twins, the investigation and the investigators' lack of knowledge of the appropriate procedures to follow in conducting this inquest delayed the return of these infants to their mother. The mother, who was recovering in a nearby community hospital, was thus denied access to her infants during a significant portion of those few days they survived. The furor caused by the presence of the investigatory team and the newspaper accounts of the incident disturbed the parents of another infant so greatly that they removed their child from Strong Memorial before its treatments had been completed, thus jeopardizing its health.
- The investigations resulting from these false accusations are disruptive and time consuming and, most importantly, impair the hospital's ability to provide proper care for all of the infants in

its nurseries by usurping the time of the medical and nursing staff that would otherwise be spent in rendering care.

- Posted notices, whether they are scattered about the units or located in the nurses' station, are seen by the families of children whose care is in no way being questioned. Those families may incorrectly infer from the notice that the hospital or some of the physicians have wrongfully withheld treatment on previous occasions. This inference would unnecessarily increase the family's anxiety when it is already under a great deal of stress. In addition to the stress to the parents, the staff of these units are demoralized by the signs and by the parents' reaction to the signs.
- By involving the state child protection agencies in the investigation of such cases, the proposed rule would seriously drain the already inadequate resources of these agencies and involve them at a time when they can lend no expertise in deciding the best course for treatment of the child. A more appropriate time for involving such agencies would be once a decision has been made that the child is treatable, but the parents refuse to allow the treatment. Then, the state child protection agencies would be acting as they might for a child of Jehovah's Witnesses to secure the rights of the child to treatment.

It is time a more thoughtful approach to this matter was seriously considered. After much deliberation and study of the issues involved, the President's Commission on Ethical Behavior in Medicine and Biomedical and Behavioral Research recommended the establishment of ethics review boards within each institution or community to address all cases involving persons of any age group in which a decision to forego life sustaining treatment must be made. Several representatives of health care provider organizations have tailored this ethics review board concept to address these cases, and the resultant Infant Bioethical Review Committees (IBRCs) are described in the proposed amendment to the Medicare Conditions of Participation submitted with the comments of the American Academy of Pediatrics. This approach offers several advantages:

- All cases of infants for whom a decision must be made regarding the provision of life sustaining treatment will be addressed by the IBRC either through determination of a hospital policy or review of the individual cases.
- The alternatives for the child can be thoroughly discussed, including the help available for people with the same disabling condition as the infant.
- The review would occur as part of normal hospital procedure for such cases, thereby minimizing the disruption of services to other seriously ill infants. Also, because the review is required for all such cases, no inferences will be made that the treatment rendered by the physician(s) and health care team involved is faulty.

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- Notice of the existence and function of the IBRC can be made in such a way as to not alarm the families of infants whose care is not in question; further, the deliberations of the IBRC on a particular case shall be made in confidence, which also will minimize the anxiety to the other parents.
- Finally, the recommendation that we are advancing would be issued under the authority of the Secretary to set conditions for participation and avoids problems associated with reliance on Section 504 which is of dubious applicability.

We strongly urge you to consider withdrawing your proposed regulation and to substitute the proposal to establish IBRCs. If my staff or I may be of further assistance in helping you to consider this matter, please contact me at (202) 828-0460.

Sincerely,
Original signed by
J. A. D. COOPER, M.D.

John A. D. Cooper, M.D.

APPENDIX

CONDITION OF PARTICIPATION: Infant Bioethical Review Committee Proposed 42 C.F.R. §482.____

The governing body must appoint an infant bioethical review committee (IBRC) or must join with one or more other hospitals to create a joint IBRC for the purposes of:

- (1) providing advice when decisions are being considered to withhold or withdraw from infants life-sustaining medical or surgical treatment;
- (2) recommending institutional policies concerning the withholding or withdrawal of medical or surgical treatments to infants, including guidelines for IBRC action for specific categories of life-threatening conditions affecting infants; and
- (3) reviewing retrospectively infant medical records in situations in which life-sustaining medical or surgical treatment has been withheld or withdrawn.

A. Standard: Organization and Staffing.

The IBRC shall consist of at least 8 members and include the following:

- (1) a practicing physician (e.g., a pediatrician, a neonatologist, or a pediatric surgeon)
- (2) a hospital administrator
- (3) an ethicist or a member of the clergy
- (4) a representative of the legal profession (e.g., judge)
- (5) a representative of a disability group, developmental disability expert, or parent of a disabled child
- (6) a lay community member
- (7) a member of the facility's organized medical staff
- (8) a practicing nurse

The hospital shall provide staff support for the IBRC, including legal counsel. The IBRC shall meet on a regular basis, or as required under subsection B(3), below. It shall recommend to the steering committee of the medical staff and the governing board such administrative policies as terms of office and quorum requirements.

The IBRC shall recommend procedures to ensure that both hospital personnel and patient families are fully informed of the existence and functions of the IBRC and its availability on a 24-hour basis.

B. Standard: Operation of IBRC.

1. Prospective policy development.

The IBRC shall develop and recommend for adoption by the governing body institutional policies concerning the withholding or withdrawal of medical treatment for infants with life-threatening conditions. These shall include guidelines for management of specific types of cases or diagnoses, e.g., Down's Syndrome and spina bifida, and procedures to be followed in such recurring circumstances as, e.g., brain death and parental refusal to consent to life-saving treatment. The governing body, upon recommendation of the IBRC, may require attending physicians to notify the IBRC of the presence in the facility of an infant with a diagnosis specified by the IBRC, e.g., Down's Syndrome and spina bifida.

In recommending these policies and guidelines, the IBRC shall consult with medical and other authorities on issues involving disabled individuals, e.g., neonatologists, pediatric surgeons, county and city agencies which provide services for the disabled, and disability advocacy organizations. It shall also consult with appropriate committees of the medical staff, to ensure that the IBRC policies and guidelines build on existing staff by-laws, rules and regulations concerning consultations and staff membership requirements. The IBRC shall also inform and educate hospital staff on the policies and guidelines it develops.

2. Retrospective record review.

The IBRC, at its regularly-scheduled meeting, shall review all interim records involving withholding or termination of medical or surgical treatment to infants consistent with hospital policies developed pursuant to this condition, unless the case was previously before the IBRC pursuant to subsection B(3), below. If the IBRC finds that a deviation was made from the institutional policies in a given case, it shall conduct a review and report the findings to the steering committee of the medical staff and hospital board for appropriate action.

3. Review of specific cases.

In addition to regularly-scheduled meetings, interim IBRC meetings shall take place under specified circumstances to permit review of individual cases. The hospital shall require in each case that life-sustaining treatment be continued, until the IBRC can review the case and provide advice.

a. Convening of interim meetings.

(i) Interim IBRC meetings shall be convened within 24 hours when there is disagreement between the family of an infant

and the infant's physician as to the withholding or withdrawal of treatment, or when a preliminary decision to withhold or withdraw life-sustaining treatment has been made, consistent with hospital policies developed pursuant to this condition.

(ii) Such interim IBRC meetings shall take place upon the request of any member of the IBRC or hospital staff or family member. The identity of persons making such requests shall remain confidential, and such persons shall be protected from reprisal. When appropriate, the IBRC or a designated member shall inform the requesting individual of the IBRC's recommendation.

(iii) The IBRC may provide for telephone and other forms of review when the timing and nature of the case, as identified in policies developed pursuant to B(1), make the convening of an interim meeting unfeasible.

b. Conduct of interim meetings.

Interim meetings shall be open to the affected parties. The IBRC shall ensure that the interests of the parents, the physician, and the child are fully considered; that family members have been fully informed of the patient's condition and prognosis; that they have been provided with a listing which describes the services furnished by parent support groups and public and private agencies in the geographic vicinity to infants with conditions such as that before the IBRC; and the IBRC shall facilitate their access to such services and groups.

c. Treatment effect.

In cases in which there is disagreement on treatment between a physician and an infant's family, and the family wishes to continue life-sustaining treatment, the family's wishes shall be carried out, for as long as the family wishes, unless such treatment is medically contraindicated. When there is physician/family disagreement and the family refuses consent to life-sustaining treatment, and the IBRC after complete information and due deliberation agrees with the family, the IBRC shall recommend that the treatment be withheld. When there is physician/family disagreement and the family refuses consent, but the IBRC disagrees with the family, the IBRC shall recommend to the hospital board that the case be referred immediately to an appropriate court or child protective agency, and treatment shall be continued until such time as the court or agency renders a decision or takes other appropriate action. The IBRC shall also follow this procedure in cases in which the family and physician agree that life-sustaining treatment should be withheld or withdraw, but the IBRC disagrees.

C. Standard: Form and Retention of Records.

The IBRC shall maintain records of all of its deliberations and summary descriptions of specific cases considered and the disposition of those cases. Such records shall be kept in accordance with institutional policies on confidentiality of medical information. They shall be made available only upon court order, or to properly authorized staff of accrediting organizations or government agencies. In such instances, patient identification shall not be disclosed.