aamc association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

ADMINISTRATIVE BOARD

WEDNESDAY, JANUARY 21, 1987
6:00 PM - 7:00 PM
JEFFERSON EAST

THURSDAY, JANUARY 22, 1987
8:00 AM - 8:30 AM
JEFFERSON WEST

8:30 AM - 12:00 PM
CAUCUS ROOM

WASHINGTON HILTON HOTEL
WASHINGTON, DC

one dupont circle, n.w./washington, d.c. 20036

Thursday, January 22, 1987

8:00 am - 8:30 am
Jefferson West

Joint Administrative Boards Session

Presentation on Health Manpower Issue

(A continental breakfast will be available at 7:45 am)

8:30 am - 12:30 pm
Caucus

COUNCIL OF DEANS
ADMINISTRATIVE BOARD MEETING

Washington Hilton Hotel
Washington, DC

AGENDA

Wednesday, January 21, 1987

4:00 pm - 6:00 pm
Jefferson West

I. Executive Council Executive Session

6:00 pm - 7:00 pm
Jefferson East

II. Joint Administrative Boards Session

Guest Speaker: Congressman Henry Waxman

7:00 pm - 10:00 pm
Monroe West

Reception & Dinner

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

September 10, 1986
5:00 p.m. - 6:30 p.m.
Georgetown East Room

September 11, 1986
8:00 a.m. - 12:00 p.m.
Edison Room

Washington Hilton Hotel
Washington, D.C.

PRESENT
(Board Members)

William Butler, M.D.
D. Kay Clawson, M.D., Chairman
Robert Daniels, M.D.
William B. Deal, M.D.
John W. Eckstein, M.D.
Louis J. Kettel, M.D.*
Walter F. Leavell, M.D.
Richard Ross, M.D.*

(Guests)
Vicki Darrow
John Gronvall, M.D.*
Richard Janeway, M.D.*
Richard Peters, M.D.
Edward J. Stemmler M.D.*
Virginia Weldon, M.D.*

ABSENT
Arnold L. Brown, M.D.
Richard Moy, M.D.
John Naughton, M.D.

(Staff)

David Baime
Robert Beran, Ph.D.*
Janet Bickel
Melissa Brown*
Debra Day
James B. Erdmann, Ph.D.
Robert F. Jones, Ph.D.
Thomas J. Kennedy, M.D.
Joseph A. Keyes, Jr.
Richard Knapp, Ph.D.*
Robert G. Petersdorf, M.D.*
James R. Schofield, M.D.
Nancy Seline*
John F. Sherman, Ph.D.
August Swanson, M.D.*
Kathleen Turner*

*Present for part of meeting

I. CALL TO ORDER

The meeting was called to order at 5:10 p.m. on September 10, 1986 by D. Kay Clawson, M.D., chairman.

II. INSTITUTIONAL POLICIES ON AIDS

The Board considered survey information collected by Dr. Robert Beran, director, Division of Student Programs, on draft institutional policies regarding the management of students and employees who had contracted AIDS. Dr. Clawson also provided some guidelines developed at his institution. The Board reaffirmed that the AAMC should be active and visible on this issue by serving as a clearinghouse for information but should not develop model guidelines for policies. Since institutional policies were in continued development, the Board encouraged Dr. Beran to update his files through another survey and to seek documents that were not limited to students with AIDS but included the management of other medical center personnel as well.

III. APPROVAL OF MINUTES

The minutes of the June 18-19, 1986 meeting of the COD Administrative Board were approved as submitted.

IV. CHAIRMAN'S REPORT

Dr. Clawson reported on the meeting of the Executive Committee:

- The Association recently underwent a routine annual audit.
- Up to five percent of monies earned from investments retroactive to July, 1985 were being earmarked for expenses of the transition in leadership.
- The FY 1987 budget as revised was accepted by the Committee.
- The Society for Health and Human Values had asked the AAMC to join in a request for support from Robert Wood Johnson for a fellowship in ethics and a center to be housed at the University of Chicago. The Committee endorsed AAMC support for the concept of the fellowship, conditioned upon the satisfactory clarification of certain matters, but decided that it was inappropriate to support the center. This is in line with a general policy of declining to endorse an activity specific to one of the AAMC's member institutions.
- The Committee also declined to have the AAMC endorse a proposal for a study by Federated Consultants.
- The Executive Committee decided to give Edithe Levit, M.D., president-emeritus of the NBME, a special recognition award at the annual meeting.

V. ACTION ITEMS

A. Nomination of Distinguished Service Members

Dr. Eckstein reported that a committee established for the purpose of nominating individuals for distinguished service membership had recommended Dr. Sherman Mellinkoff. The committee had also considered other nominees but concluded that it would be appropriate to limit the recommendations to Dr. Mellinkoff this year. A discussion ensued which confirmed that the criteria used by each of the Councils were not consistent. It also confirmed that this required a judgment call on the part of the committee and board. Election is an honor to be confirmed on those judged to be worthy; no criteria can anticipate the varieties or levels of service prospectively.

Action: On motion, seconded, and passed unanimously, the Board recommended Dr. Sherman Mellinkoff for nomination as an AAMC distinguished service member.

B. Site for 1988 Spring Meeting

The Board endorsed the staff recommendation to hold the 1988 spring meeting at the Hotel Inter-Continental at Hilton Head, South Carolina.

C. Social Event for 1986 Annual Meeting

The Board approved the arrangements made by Drs. Clawson, Daniels, Hamlin and AAMC staff for a Sunday evening reception and dinner at the New Orleans Board of Trade. Dr. Hamlin, dean, Tulane University School of Medicine, had arranged the event to be subsidized by funds received by his school in the amount of $5,000, thus reducing the per person price to $46.00.

D. California Ballot Proposal

The Board considered an amendment to the November 1986 California Ballot which proposed a ceiling of $64,000 for salary and fringe benefits of state employees, including faculty members of the state medical schools.

Action: On motion, seconded and passed unanimously, the Board endorsed a staff proposal to send a letter of support to the coalition formed to fight the proposition. The Board recommended declining the coalition's request for a financial contribution.

ADJOURNMENT/RECONVENING

The meeting was temporarily adjourned and reconvened at 8:00 a.m., September 11, 1986.

E. NIH Centennial Celebration

Action: On motion, seconded and passed unanimously, the Board endorsed an AAMC donation of $5,000 to the NIH Centennial Committee and the adoption of the following resolution in honor of the NIH Centennial:

WHEREAS the National Institutes of Health is observing the one hundredth anniversary of the establishment of the Hygenic Laboratory, its progenitor agency for the scientific investigation of human disease; and

WHEREAS the National Institutes of Health has achieved international preeminence through the conduct and support of innovative and distinguished biomedical and behavorial research; and

WHEREAS the National Institutes of Health has been an effective and creative partner with our academic medical centers in advancing the search for new knowledge to improve the health of our citizens;

BE IT RESOLVED that the Association of American Medical Colleges offers its congratulations on the occasion of the centennial celebration of the National Institutes of Health and its best wishes and high hopes for an even more fruitful next century.

F. Score Reporting for the NBME Examinations

Dr. Weldon appeared before the Board to express her uneasiness with the limited discussion preceding the action taken by the Executive Council at its last meeting regarding NBME score reporting, namely that the AAMC should use its influence to encourage the National Board of Medical Examiners to report scores for its examinations on a pass-fail basis only. The motion was introduced under new business by the COD. The COTH had not discussed the issue at its Board meeting. While not implying in any way that the action taken was wrong, Dr. Weldon planned to ask the Executive Council to consider re-opening the issue for further discussion by the Councils and to allow an expression of views from the Group on Student Affairs. Further discussion revealed that the Board was resolute in its position on the action taken but sympathetic to the concerns expressed by Dr. Weldon.

Action: On motion, seconded and passed unanimously, the following resolution was adopted:

> The Council of Deans reaffirms its position on favoring a pass-fail only reporting system for the NBME examinations, as taken at its June, 1986 meeting. However, in order that further discussion of the issue among AAMC members may take place, it recommends that the AAMC withhold implementation of action on the position until the January, 1987 Executive Council meeting.

G. Ambulatory Care Training Act

Dr. Knapp outlined the major features of S. 2670, the Ambulatory Care Training Act, a bill introduced by Senators Kennedy (D-MA) and Heinz (R-PA) to provide support for graduate medical education in ambulatory care sites.

The Board discussed in turn five major provisions of the bill. First, the Board reaffirmed AAMC policy on the primacy of the hospital as the institution through which funds for graduate medical education should flow. This position was not taken however without some concerns raised

that developments in faculty practice organization may render such a position less tenable in the future.

The Board supported the concept of incentives to promote training in particular specialties, e.g., geriatrics, but opposed the use of weighting factors contained in the bill. Special project grants were viewed as a better mechanism for this purpose.

The Board decided that it could not oppose the provision for the publication by HCFA of hospital specific information on Medicare educational payments. Dr. Knapp warned that such a report would show an unacceptable variation among institutions in costs per resident.

The Board found the bill's proposed reduction in direct medical education payments for foreign medical graduates consistent with AAMC policy.

A final provision which linked reductions in the number of residents counted for the direct medical education payments to those counted for the indirect adjustment was opposed. The indirect medical education adjustment uses resident counts only as a proxy to account for differences in severity of illness. Therefore, all residents counted in the development of the regression equation should be included in the application of that equation to the funding mechanism.

Dr. Knapp informed the Board that the AAHC was supporting the bill. He argued that as a tactical matter it might be wise for the AAMC to take no official position at this time. It was not clear that the bill would go anywhere. As Congress continued to look for ways to cut the budget, it was in the AAMC's interest to keep "money" issues off the table.

VI. OSR REPORT

Dr. Peters reported that the recent issue of the OSR Report featured articles on medical liability and affirmative action. The OSR had completed its plans for the annual meeting program which would include sessions on access to medical education, access to health care, and problem-based learning, as well as a general session on the future of medicine.

VII. INFORMATION ITEMS

A. Ad Hoc Committee on Strategies for Promoting Academic Medical Centers

Dr. Clawson announced that a joint AAHC-AAMC committee had been appointed to examine strategies for promoting academic medical centers. The Committee was soliciting comments from deans and others via a mail questionnaire.

B. Legislative Report

Dr. Kennedy referred the Board to a written summary of the status of legislation of interest, including FY 1987 HHS appropriations, Gramm-Rudman sequestration estimates, tax reform, budget reconciliation, VA

appropriations, and animal research as well as the status of DHHS policies on indirect costs. He made several corrections to that written record. He highlighted a puzzling disparity in the growth of indirect costs on NIH versus NSF grants. Dr. Kettel confirmed that it was a common practice for the NSF to ask investigators to negotiate with their institutions a lower cost rate.

VIII. DISCUSSION WITH DR. PETERSDORF

Dr. Petersdorf addressed some brief remarks to Board members and invited their questions or comments on his directions for the AAMC as the newly appointed president. He announced plans to develop a strategic planning process to set goals for the next five years. A data gathering phase involving the constituency at large would be the first step. He found the staff to be extremely able, but was aware of some dyshomeostasis in staffing patterns which he intended to address. An example was the Department of Academic Affairs. It was responsible for many of the programs and projects of interest to deans, but had an organizational line to the Council of Academic Societies.

Dr. James Bentley had been made a member of the Executive Staff and Dr. John Sherman would assume a true deputy president role under his administration.

AAMC programs and policies appeared fundamentally sound. The effectiveness of the AAMC style in advocating policies needed to be investigated. Dr. Petersdorf encouraged the deans to visit or call him with their ideas and suggestions as he undertook an organizational assessment over the next year.

In response to questions, Dr. Petersdorf acknowledged that the AAMC leadership was involved in sensitive discussions with the AAHC on the relationship between the two organizations, but that any comment on those discussions would be premature. He expressed his hope that he could encourage fuller participation of more deans in AAMC activities. The Association's role on Capitol Hill and relationship with university presidents were areas that he intended to devote a great deal of attention. As a member of the search committee for a new VA chief medical director, Dr. Petersdorf was encouraged that veteran status would not be an absolute requirement for that appointment.

IX. POINT OF PERSONAL PRIVILEGE

Dr. Kettel thanked the staff for providing meeting materials in binder form.

X. AMA-AHA-AAMC CONFERENCE ON THE ATTRACTIVENESS OF MEDICINE

Dr. Kettel announced that the joint AMA-AHA-AAMC conference this coming year would examine changes in the medical profession and its attractiveness to young people. It would be held in Los Angeles, California near the end of February, with specific dates to be determined. He encouraged the deans to give it attention on their calendars.

XI. VA OPEN HEART SURGERY RECOMMENDATIONS

Dr. John Gronvall, acting chief medical director of the VA, updated Board members on that agency's review of its open heart surgery programs. He emphasized that the review, which might result in the closing or consolidation of programs, was motivated purely by quality of care concerns, not by budgetary needs. Guidelines had been developed for minimum caseloads and maximum mortality rates. Two task forces had been appointed, one specifically examining the effect of potential consolidation on facility resources, physical plant environment, and medical school affiliations. To examine those issues, the task force had mailed questionnaires to each VA medical center. Dr. Gronvall expected that the VA would conduct similar reviews in other areas, e.g., neurosurgery and organ transplantation. He hoped that these VA reviews would gain the informed support of the AAMC.

In response to questions, Dr. Gronvall indicated that decisions on programs closures would be made by December, 1986. After receiving the task force reports, teams would be organized to visit 6-10 centers to collect further information. He did not expect political pressures to influence the decisions. The proximity of centers for patients and their families would be considered. Centers earmarked for closing would be phased out over an 18-month to two year period.

On another issue, Dr. Gronvall indicated that the Inspector General was proceeding with his investigation of conflict of interest violations by VA faculty members. Of the first group investigated, only a handful of individuals were identified as committing egregious offenses. Dr. Dorothy Rosinski was working with Mr. Keyes of the AAMC and others to develop a new policy statement, guidelines that would demand high ethical standards while addressing the real concerns of those in academic medicine about overly stringent and impractical regulations.

XII. ADJOURNMENT

The meeting was adjourned at 11:48 a.m.

NATIONAL BOARD OF MEDICAL EXAMINERS®

3930 CHESTNUT STREET, PHILADELPHIA, PA. 19104

TELEPHONE: AREA CODE 215-349-6400 · · · CABLE ADDRESS: NATBORD

OFFICE OF THE PRESIDENT

January 6, 1987

Robert G. Petersdorf, M.D.
President
Association of American Medical Colleges
One Dupont Circle NW
Washington, D.C. 20036

Dear Dr. Petersdorf:

As a result of certain legislative initiatives in New York, the National Board of Medical Examiners (NBME) has been asked to change its eligibility requirements to admit students and graduates of foreign medical schools to its Part I and Part II examinations. This issue will be brought to the full Board at its Annual Meeting on March 26-27, 1987.

Present policy and supporting rationale regarding current eligibility requirements are described in the enclosed position paper for your review. It would be useful for the Board to know the view of your organization before a change in NBME policy is considered. Because the implications are so great, the NBME does not wish to act without consulting groups who have a legitimate interest in this question.

Sincerely,

Robert L. Volle, Ph.D.
President

Enclosure
Similar Communications Sent to the Following Organizations:
- Accreditation Council for Graduate Medical Education
- American Board of Medical Specialties
- American Hospital Association
- American Medical Association
- American Medical Student Association
- Council of Medical Specialty Societies
- Educational Commission for Foreign Medical Graduates
- Federation of State Medical Boards of the United States, Inc.
- Joint Commission on Accreditation of Hospitals
- Liaison Committee on Medical Education
- Resident Physicians Sections/AMA
- Student National Medical Association, Inc.
- Surgeon General of the United States Air Force
- Surgeon General of the United States Army
- Surgeon General of the United States Navy
- Surgeon General of the United States Public Health Service
- Veterans Administration

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January 1987

The Policies of the National Board of Medical Examiners Regarding Eligibility for Its Certification and for Its Certifying Examinations

The National Board of Medical Examiners (NBME) has as its primary purpose the preparation and administration of high quality examinations, the successful completion of which, together with the successful completion of all educational requirements established by the National Board, lead to issuance of its certificate. The purpose of the NBME certificate is to provide a record of qualification for the individuals certified, which the legal agencies governing the practice of medicine within each state may, in their discretion, rely upon in making medical licensure decisions regarding those individuals.

Such licensure decision-making may be defined as a process by which a governmental agency grants permission to an individual to engage in a given occupation or profession upon finding that the individual has attained the minimal level of competency required to ensure that the public health, safety, and welfare will be reasonably well protected. By contrast, certification may be defined as a voluntary process by which a non-governmental agency grants recognition to an individual who has met certain predetermined qualifications set by that certifying agency. These two processes are related in that the purpose of certification is to enable the public, represented by the state licensing authorities, to identify those individuals who have voluntarily met a standard that is usually set above the minimum level required for purposes of licensure.

The granting of the NBME certificate requires that the individual certified has (1) received the M.D. degree from a medical school in the U.S. or Canada accredited by the Liaison Committee on Medical Education (LCME); (2) has passed Parts I, II, and III of the NBME certifying examination; and (3) has completed, with a satisfactory record, one full year in a graduate medical education program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

While the certifying examinations of the NBME tend to be the more visible aspect of its certification program, the requirements for certification, noted above, clearly reflect the recognition that performance on examinations cannot be considered in isolation. Well-designed standardized examinations can and do provide reliable and valid assessments of the cognitive components of competence - knowledge, understanding, problem-solving, and important aspects of clinical judgment. However, the complete assessment of competence requires, in addition, the evaluation of clinical and interpersonal skills, as well as behavioral characteristics such as motiviation, capacity to assume responsibility, integrity, and ethical values - all equally important aspects of physician competence. These aspects of physician competence can only be assessed through direct observation over time by those responsible for the educational process.

Given this necessary combination of educational and examination requirements, the NBME, in issuing its certificate, relies not only upon its role and expertise in the field of evaluation in medicine, but also upon the judgment of other entities, to ensure that the requirements for certification have, in fact, been met. To ensure that its certifying examinations measure

knowledge relevant to and appropriate for qualification for purposes of medical licensure, the NBME relies upon the expertise of test committee members, drawn from the academic and practice communities.

With respect to the requirement relative to the receipt of the M.D. degree, the NBME relies upon verification by the medical school that the candidate has met that institution's educational objectives and has, in fact, earned the M.D. degree. The NBME's reliance upon medical school verification is based, in turn, upon the assurance that the educational standards of that school have met nationally recognized standards, as documented by LCME accreditation. Similarly, with respect to the graduate medical education requirement, the NBME relies upon the residency training program to verify that the candidate has served satisfactorily for one year of graduate study. It also relies upon the assurance that the educational standards of such programs have met nationally recognized standards, as documented by ACGME accreditation.

The NBME certification program is voluntary; voluntary in that no one is required to be certified by the NBME in order to obtain a license and also in that the NBME has taken upon itself the purpose and function of issuing this credential. The NBME has determined, as described above, what is required to issue a credential in the form of its certificate. Not all individuals who have graduated from medical school qualify for NBME certification. In some cases, the NBME cannot make representations, through its certificate, with respect to the qualification of such individuals.

For students or graduates of medical schools not accredited by LCME and, specifically, foreign medical schools, the NBME has no assurance as to whether the educational standards of the school meet nationally recognized standards.

The NBME is not an accrediting agency and cannot make determinations as to whether schools do or do not meet the nationally recognized standards of the LCME. Should the time come, however, when foreign medical schools are accredited in a manner identical to that used for LCME schools, the NBME presumably would reconsider its policy defining the eligibility requirements for certification.

Since 1958 and continuing through to the present, the NBME, working together with the Educational Commission for Foreign Medical Graduates (ECFMG), has made test questions from the NBME Part I and Part II pool of test items available for purposes of assessing knowledge in the basic and clinical sciences of students and graduates of foreign medical schools. Currently, items from the Part I and Part II pool of test items are made available by the NBME for use in the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Passing the FMGEMS is one of the several requirements for ECFMG certification, which certification program is designed to assess the readiness of graduates of foreign medical schools to enter accredited graduate medical education. A variety of procedures is used by the NBME to assure that the FMGEMS, although half the length of the NBME Part I and Part II, is comparable to those examinations in terms of proportional content representation and in terms of difficulty. Additionally, the standards for the FMGEMS are derived from the standards for passing NBME Part I and Part II.

Given that graduates of foreign medical schools would not be using scores on the NBME certifying examinations for purposes of certification, and, given that the FMGEMS is available to provide the kinds of useful information which can be furnished by a high quality extramural assessment, it is difficult for the NBME to identify any compelling rationale for modifying its eligibility requirements for its certifying examinations.

In summary, the NBME holds that its certificate rests upon high quality examinations, as well as high quality medical education, and that the quality of medical education must be evaluated by means not limited to the performance of individuals on standardized examinations. These premises form the basis for the policies of the NBME with respect to eligibility for its certifying examinations and for its certificate, both of which rely upon nationally recognized standards of accredited medical education. It is this combination of rigorous educational and examination requirements which makes the certificate of the NBME a meaningful credential which may be relied upon by state medical boards for purposes of licensure. The meaningfulness of the NBME certificate, and its resulting utility to state medical boards, is attested to by the fact that it is accepted as qualification for initial licensure by 51 of the 54 medical licensing authorities in the United States and its territories.

A SUMMARY REPORT OF THE GROUP ON STUDENT AFFAIRS SURVEY OF STUDENT AFFAIRS OFFICERS RE: NBME PASS-FAIL ISSUE

The GSA conducted a survey of student affairs' officers in response to the request for consideration of the issue of pass-fail score reporting for the new NBME comprehensive examination program. The purpose of the survey was to provide the COD Administrative Board with the opinions of student affairs' officers concerning various factors associated with the use of NBME scores and their assessment of the effect of reporting only pass-fail scores.

The reporting of pass-fail scores was discussed at the 1986 GSA Spring regional meetings. Two regional recommendations emerged from these discussions--one favoring pass-fail only and one favoring pass-fail with the reporting of scaled scores to an institutional official for counseling purposes. After consideration of the wide divergence of opinion on this issue resulting from the regional meetings, the GSA Steering Committee decided to conduct the attached survey.

The questionnaire was mailed to the student affairs' officer in each U.S. and Canadian school of medicine. A total of ninety-eight individuals responded, and the attached summary represents the responses of 94 student affairs' officers of U.S. schools of medicine.

The items noted below represent a summary of the survey responses:

- Respondents do not feel generally that the NBME examinations unduly influence the content of the curriculum. They also disagreed that there exists an overemphasis in the time alloted for student preparation for the examinations or that NBME discipline group performance data should be used to evaluate a department's teaching effectiveness.

- The highest level of agreement was in response to the statement that the present NBME format results in an inappropriate emphasis on memorization and recall of fact.

- When asked to assess the effect of reporting only pass-fail scores on several factors, the majority of respondents did not feel that such reporting would require the development or modification of existing information or procedures.

- Student affairs officers were requested to assess the usefulness (on three point scales) of the presently available NBME scores and also their assessment of the usefulness of only pass-fail scores on the same factors. An examination of the average response rate values in Section II demonstrates that while some differences exist, the total resondent group feels that no major differences exist in the usefulness of the two reporting systems regarding the five statements. However, In order to compare individual respondents' assessment of the usefulness of the two score reporting systems, individual responses to the two scoring systems were plotted. The results are as follows:

COMPARISON OF USEFULNESS OF SCALED SCORES VERSUS PASS-FAIL FORMAT

	scaled scores & pass-fail are same	pass-fail is more useful than scaled scores	pass-fail is less useful than scaled scores
	%	%	%
Areas of Assessment			
Student Academic Performance*	58.4	21.3	20.2
Strengths and Weaknesses of Curriculum Efforts For Internal Use	38.4	10.5	51.2
Student Performance for Residency Program Directors	45.7	18.5	35.9
Undergraduate Medical Education Curriculum for Internal Evaluation	56.5	6.5	37.0
Effectiveness of Undergraduate Medical Education for LCME	68.1	12.1	19.8

*Row percentages may not add to 100 due to rounding

The table indicates that the majority of student affairs' officers thought that scaled scores and pass-fail reporting were similar in their usefulness for evaluating student academic performance and for evaluating undergraduate medical education curriculum for internal purposes as well as for LCME accreditation. In contrast, over half of the respondents felt that pass-fail reporting would be less useful than scaled-score reporting for internally evaluating the strengths and weaknesses of basic and clinical science departments.

As expected, there exists no clear preference for a specific score reporting format among student affairs officers. Only 19 respondents (21.8%) chose the reporting of only pass-fail scores to students, schools or programs (as called for in the Executive Council motion). A small number, 10 respondents (11.5%), suggested that the NBME continue its current system of score reporting for the new comprehensive examination. The majority of respondents (58.6%) favored pass-fail reporting, supplemented by other information, e.g., overall scale scores, group performance data, etc.

Of those respondents who favored some change in score reporting, 84.6 percent favored changing the score reporting format on the current version of NBME Parts I and II prior to the implementation of any new comprehensive examination.

SUMMARY OF GSA SURVEY OF STUDENT AFFAIRS OFFICERS RE: NBME PASS-FAIL ISSUE
N = 94 Respondents

I. INFLUENCE OF NBME SCORES

Please indicate your degree of concurrence with each of the following statements. For those statements concerning institutional practice, please answer according to the current practice of your institution. For statements regarding NBME score reporting, please answer according to the current NBME score reporting system.

strongly disagree — neither agree nor disagree — strongly agree
1 2 3 4 5

Average: 2.88 A. The content of NBME examinations unduly influences the content of the curriculum.

2.41 B. The institutional expectation of "good" departmental performance results in an overemphasis in the time allotted for student preparation for the examination.

2.35 C. NBME discipline group performance (means) should be used to evaluate a department's effectiveness in the curriculum.

3.89 D. The present format of the NBME examination results in inappropriate emphasis on memorization and recall of fact.

3.67 E. Students' NBME Part I and II scores are being requested by the majority of the residency programs to which our students apply.

II. EFFECT OF PASS-FAIL

To complete this section, you are requested to answer the question in italics for each of the statements noted below. In developing your response, you are to assume that only pass-fail scores are available for the NBME Part I and II examinations.

"Would the reporting of only pass/fail scores require your institution to supplement or modify information (procedures) related to...

YES	NO	
19.0%	81.0%	...the academic performance of students (for internal student promotion decisions only)?"
41.5%	58.5%	...the analysis of the strengths and weaknesses of the curriculum efforts of basic and clinical science departments (for internal diagnostic use)?"
26.1%	73.9%	...the provision of student performance information to residency program directors?"
43.6%	56.4%	...the overall evaluation of the undergraduate medical education program (for purposes of internal program evaluation)?"
32.6%	67.4%	...the evaluation of the effectiveness of the undergraduate medical education program for use in the LCME accreditation process?"

III. NBME SCORE REPORTING FORMAT

You are requested to assess the effect of two different score reporting formats for the NBME Part I and Part II examinations. For each of the statements in Sections A and B, please indicate the degree of usefulness on a scale of 1 (not useful) to 3 (very useful). The first scoring format (A) represents the current system of reporting scaled scores. For Section B, you are to assume the reporting of only pass-fail scores.

A. Scaled Scores (presently in use)

Please assess the usefulness of the presently available NBME scaled scores for evaluating each of the following:

1 not useful 2 useful 3 very useful

Average: 1.66	1.	student academic performance (for internal student promotion decisions only)
1.79	2.	strengths and weaknesses of curriculum efforts of basic and clinical science departments (for internal diagnostic use only)
1.67	3.	student performance provided to residency program directors
1.69	4.	the undergraduate medical education curriculum (for purposes of internal overall program evaluation)
1.54	5.	the effectiveness of the undergraduate medical education curriculum for use in the LCME accreditation process

B. Pass-Fail (proposed)

You are now requested to assess the usefulness of NBME pass-fail scores for evaluating each of the following:

1 not useful 2 useful 3 very useful

Average: 1.78	1.	student academic performance (for internal student promotion decisions only)
1.31	2.	strengths and weaknesses of curriculum efforts of basic and clinical science departments (for internal diagnostic use only)
1.42	3.	student performance provided to residency program directors
1.39	4.	the undergraduate medical education curriculum (for purposes of internal overall program evaluation)
1.45	5.	the effectiveness of the undergraduate medical education curriculum for use in the LCME accreditation process

IV. Please check the one statement with which you concur:

21 A. I support the reporting of only pass-fail scores to students, schools and programs with the provision that individual discipline scores for students also be reported to a single institutional official at each medical school to be used for counseling or the evaluation of coursework.

19 B. I support the reporting of only pass-fail scores to students, schools and programs.

29 C. I support the proposal of the NBME study committee to report pass-fail scores and an individual overall scaled score to students. Additionally, pass-fail scores, individual overall scaled scores and group (class) performance data by discipline would be available to schools.

4 D. I do not believe the AAMC should take a position on the issue of the NBME score reporting.

17 E. I do not concur with any of the statements above and propose the following alternative or recommendation:

Of the 17 responses, 10 suggested keeping the current system.

YES NO

59 10 If you checked statements A, B or C, do you favor changing the score reporting format on the current version of NBME Parts I and II (prior to implementation of the new comprehensive examination)?

MEDICAL CARE FOR THE INDIGENT

At their meeting of September, 1986, the Midwest deans developed the attached statement on medical care for the indigent for consideration by the COD Administrative Board.

The AAMC's recent statements on this issue can be summarized briefly. At its September, 1983 meeting, the COTH Administrative Board reached a consensus that the two major policy issues requiring attention and increased emphasis were the financing of both charity care and graduate medical education under price-oriented payment systems. In September, 1984, Dr. Haynes Rice presented an AAMC statement (see attached) on "Uncompensated Care and the Teaching Hopsital," to the National Council on Health Planning and Development, DHHS (the same statement was presented later that month by Dr. Robert Heyssel to the U.S. Senate Subcommittee on Health, Committee on Finance). In the statement, the AAMC expressed concern about the effect of the uneven distribution of uncompensated care across hospitals in a price-conscious competitive environment. In July, 1985, Dr. James Bentley testified before the Senate Subcommittee on Health, Committee on Finance, regarding Medicare's prospective payment system. The AAMC argued that the higher costs to hospitals of indigent Medicare patients was an appropriate expense for the Medicare Trust Fund.

The AHA and AMA have been active on the issue of indigent care. The AHA has proposed both long and short-term initiatives to the financing of indigent care, involving both the public and private sectors (see attached executive summary of report). The AMA's Council on Medical Service has prepared several reports, including one on the characteristics of the uninsured and underinsured populations (see attached). In the last year, the AMA has used these data to develop proposals targeted at various subgroups of these populations, which center on the development by states of risk pools. A concise summary of these recommendations is currently being prepared by AMA staff.

The position paper adopted by the Midwest deans contains a number of admonitions for the AAMC which the Board should consider:

- There is adequate money available within the current system for the proper care of the indigent if the services were properly organized and emphasized preventive care.
- It is important for the AAMC to make a public commitment to the care of the indigent both to contribute to the national dialogue on the subject and to clarify public perceptions as to the non-self-serving character of our interest.
- An important role for the Association is to develop not only a commitment to a provision of quality care, but a mechanism by which the quality of care can be assessed and evaluated.

Recommendation: That the Board consider the position paper formulated by the Midwest Deans and discuss the appropriate role and position of the AAMC with respect to the issues raised.

HEALTH CARE FOR THE MEDICALLY INDIGENT
POSITION PAPER
MIDWEST/GREAT PLAINS DEANS

At its meeting in September, 1986, members of the Midwest/Great Plains Section of the Council of Deans and invited representatives from the AAMC and its governance structure addressed the issue of the role academic institutions might play in improving the health care provided to the medically indigent. During the first half day of the meeting, deans from four separate areas of the country described unique approaches that have been tried in their communities to address the problem. The second half day was spent discussing the following:

a. What issues concerning quality and access should be addressed by academic institutions?

b. How should academic medical centers integrate missions in education and research into a system of health care for the medically indigent?

c. What are options for financing a better level of health care for the medically indigent; is capitation the best approach?

d. What are the political ramifications of academic institutions taking a more active role in addressing the problem of improving the delivery of health care to the medically indigent?

The discussion of these questions led to several points of agreement. For example, the term medically indigent should include not only the traditional public aid recipients but also those who are uninsured or underinsured. A high proportion of the approximately 40 million people in these categories are employed but either cannot participate in group insurance programs or cannot afford the premiums. There also was general agreement that there are few acceptable measurements of the quality of health care. An early requirement is to work with other entities in organized medicine to define quality and defend it in all components of the delivery system.

A multitude of problems relating to financing health care to the medically indigent were discussed. Suggestions for funding this care include expanding government programs such as Medicare/Medicaid, dismantling Medicaid and reorganizing reimbursement for nursing home care, etc., developing a risk pool for commercial insurance companies to be reimbursed by government for care rendered, pursuing a federal or state capitation system. The issue is complex, but many feel there is enough money in the system, if it is utilized to emphasize health education and prevention of illness rather than crisis intervention.

The political implications of a more proactive role of academic medical institutions in focusing attention on this issue are extensive. It is imperative to clarify and communicate our motives, help increase the power base of and advocacy for the medically indigent, and work with other organizations such as the AMA. The latter could be facilitated by working with state associations and supporting the activities of the Section on Medical Schools in the AMA.

The following represents a statement of positions the Midwest/Great Plains Deans suggest for adoption by the Administrative Board of the Council of Deans:

1. A diverse population of patients from all socio-economic, cultural and ethnic groups in our society is an important element in the educational experience of today's medical students and house staff, and should be cultivated by academic medical centers.

2. Academic medical centers must include within their research missions not only the typical clinical and epidemiological study of medical problems among economically disadvantaged populations, but must be leaders in developing, modeling and evaluating innovative approaches to delivering and financing medical care for the poor and medically indigent.

3. The system of medical care in which our students and residents learn must increasingly reflect the system in which they will practice medicine. Thus, appropriate ambulatory care programs must be incorporated into those educational experiences. That same system of care must be provided in our academic medical centers for the poor and medically indigent.

4. Academic medical centers and their leaders must be strong advocates for methods of financing health care for the poor and medically indigent that will ensure viability of this linkage between our academic mission and our commitment to providing care in a modern, relevant system of care.

By taking a stance on the issue of health care for the medically indigent, the AAMC may serve as a catalyst for beneficial change and can begin the process of improving its image with those who think it traditionally only takes positions that are self-serving.

10/25/86

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Uncompensated Care and the Teaching Hospital

Presented to the
National Council on Health Planning and Development
Department of Health and Human Services

by
Haynes Rice, Hospital Director, Howard University Hospital
and Chairman, Council of Teaching Hospitals

September 13, 1984

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges is pleased that the National Council on Health Planning and Development is conducting a two-day hearing on "Uncompensated Care in a Competitive Environment." As the hospitals of our nation confront and adapt to a more traditional commercial marketplace, we must give adequate attention and respond to both the health care needs of our poorer citizens and the financial needs of the hospitals and health professionals who care for them.

Because of the long and distinguished history of hospitals such as Bellevue Hospital Center in New York, Cook County Hospital in Chicago, and Los Angeles County Hospital, many people perceive the non-Federal members of the Association's Council of Teaching Hospitals (COTH) as "charity care teaching hospitals." Charity care and medical education are assumed by some to be necessarily interdependent objectives of major medical centers. There is some validity to this perception. First, in 1980, non-Federal COTH members, which comprise 6% of the nation's community hospitals and 18% of their admissions, incurred 35% of the bad debts and 47% of the charity care. Secondly, many municipally-sponsored "charity" hospitals historically have had difficulty recruiting an adequate number of physicians. To provide appropriate and necessary medical services to their patients, those hospitals have often affiliated with local medical schools to obtain the professional medical services which are provided by residents training under faculty supervision. These affiliation arrangements have benefitted both the patients receiving care and the physicians receiving supervised training. Thirdly, when states and municipalities have authorized appropriated funds to help finance hospitals with disproportionate charity care populations, the funding has sometimes been given

an educational label to either increase its political acceptability or to channel it to particular hospitals. These three relationships between teaching hospitals and charity care have left many in our nation with the stereotypical view that the terms "teaching hospital" and "charity care hospital" are synonomous.

This perception is not completely accurate, and its perpetuation can hamper appropriate discussions of the options for addressing uncompensated care. It should be noted that the uncompensated care burden of COTH members is bimodal: some COTH members, both publicly owned and not-for-profit, provide vast amounts of uncompensated care but many provide an amount comparable to non-teaching, non-profit hospitals. Secondly, it must be recognized that medical students and residents can be trained without charity care patients. Therefore, if the issue of uncompensated care is to receive the attention it deserves at this hearing, we must separate the issues of uncompensated care and medical education wherever possible and address them separately. Therefore, the balance of this statement will focus primarily on financial and organizational impacts of providing necessary care to patients who do not pay for it.

At the outset, several observations should be made to help ensure a common frame of reference. First, major amounts of uncompensated care are presently being provided by the nation's hospitals. The expenses necessary for this care -- staff, supplies, facilities, and equipment -- are already in the present hospital system. While the financing of those services is a "hodge-podge" of cost shifting, philanthrophy, lost earnings and appropriations, hospitals currently are able to provide massive amounts of uncompensated care. What is most at risk in the re-structured environments is that the self-focused cost

containment efforts of individual third party payers will silently squeeze the present level of funding for uncompensated care out of the system.

This is related to a second observation: the increases in the price consciousness of buyers of hospital services places hospitals with large uncompensated care burdens at a significant and growing disadvantage. In the absence of a comprehensive entitlement program for financing health services of the poor and medically indigent, hospitals have historically set their prices to subsidize uncompensated care with funds from their paying patients. In a marketplace of price sensitive consumers, hospitals which attempt this cost shifting to underwrite uncompensated care will be at a disadvantage. Their necessarily higher prices will make them less attractive to paying patients, and, as paying patients choose cheaper hospitals without the uncompensated care "surcharge," the financial problem of the hospital with a major uncompensated care burden will get worse and worse.

This leads directly to the third observation: the increasingly competitive marketplace for hospital services is forcing hospitals to balance the costs of uncompensated care for current patients with the hospital's fiduciary responsibility to remain viable in order to serve future generations of patients. It is a major ethical dilemma when a hospital finds that adequately serving its present community may preclude its ability to serve in the future.

Finally, the AAMC must note that teaching hospitals have historically filled special missions as a consequence of their location. Teaching hospitals are primarily in metropolitan areas; the largest are generally in inner city neighborhoods. In response to the hospital's location and the area's shortage of

health personnel, teaching hospitals have often established large clinics and primary care services to meet neighborhood needs, even at a financial loss. The teaching hospital's area-wide programs for burn, trauma, high risk maternity, alcohol and drug abuse, and intensive psychiatric care may also attract patients unable to pay for their care. As a result, many public and private teaching hospitals are major providers of uncompensated care.

The bottom-line conclusion of these observations is clear: uncompensated care is a major problem in a competitive environment because uncompensated care is unevenly distributed across hospitals. This uneven distribution in a competitive market handicaps hospitals serving the indigent and medically indigent and benefits hospitals with primarily paying patients.

AAMC Actions

During the past year, the Administrative Board of the Council of Teaching Hospitals and the AAMC Executive Council have been engaged in a strategic planning effort for the Association's hospital activities. After a thorough review, it has been determined that one of the most important issues presently facing COTH is the future financing of uncompensated care. Association efforts are now emphasizing these priorities. The first step in developing efforts in the area of uncompensated care has been an attempt to review the research about uncompensated care patients. To date, the staff review has identified seven primary concentrations of uncompensated care:

- obstetrical and pediatric patients,
- chronically ill patients repeatedly admitted,

- o patients awaiting placement in a less than acute care setting,
- o patients admitted for catastrophic medical services such as burn or trauma care,
- o uninsured patients including the unemployed and illegal aliens,
- o patients who have abused drugs and alcohol, and
- o insured patients unable to pay copayments and deductibles.

In individual teaching hospitals, the mix of these seven types of patients varies substantially. Nevertheless, the finding that uncompensated care patients can be categorized suggests that focused responses can be developed to assist these patients.

To maintain present levels of assistance for these types of patients, the AAMC has continually lobbied Congress to retain adequate funding for the Medicaid program. The AAMC opposed the three year reduction in Medicaid funding enacted in 1981 and opposed the unsuccessful efforts to extend those reductions this year. The Association also actively supported this year's successful effort to expand Medicaid coverage for first time pregnant women, pregnant women in households where the primary wage earner is unemployed, and children under five.

The second step in developing efforts in the area of uncompensated care has been to review and follow the growing body of research seeking to identify the characteristics of hospitals with atypical burdens of uncompensated care.

Initial findings indicate that the most heavily burdened hospitals are publicly sponsored hospitals in metropolitan areas and not-for-profit hospitals in decaying inner city neighborhoods. Once again this suggests the possibility of developing categorical or focused solutions.

A number of alternative solutions are presently being tried and the Association is reviewing carefully their impact on COTH members. The all payer approved charge systems in New Jersey and Maryland have assisted COTH members with atypical uncompensated care burdens. The enthusiasm for this approach is not uniform throughout the Association membership. The recent experience in which Blue Cross of Maryland developed a preferred provider program giving patients financial incentives to use suburban hospitals with little uncompensated care rather than downtown hospitals with substantial uncompensated care costs included in approved rates may weaken the enthusiasm of those who support this approach.

Because of the recent Maryland experience, members and staff are giving increased attention to the "revenue pools" established in New York and Florida to help finance uncompensated care. These "revenue pools" are a much more recent development and their intended and unintended consequences are too recent to fully assess. In an equally preliminary way, members and staff are watching the developments in California and Arizona to see what lessons may be learned from those approaches.

The AAMC does not yet have a clear, concise, and carefully focused plan for ameliorating the problem of uncompensated care. The AAMC applauds the effort of this Council and the initiative of its chair to highlight this serious problem

and is eager to work cooperatively with others having a major interest in solving this problem.

(From 1986 AHA Report - "Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent")

I. EXECUTIVE SUMMARY

Twenty years after the creation of Medicaid, medical indigence is again becoming a major problem for a large and increasing number of Americans, and therefore a major policy issue for federal, state and local government, providers, and consumers of health care services. The growing inadequacy of governmental programs and private resources to address the needs of the medically indigent is best seen in four critical trends:

- The size and characteristics of the uninsured. In 1983, nearly 33 million Americans were without private health insurance or were not covered by governmental health benefit programs. Nearly two-thirds of the uninsured were employed or were members of families in which the head of the household was employed and often insured. However, the jobs held by the uninsured are frequently marginal. Two-thirds of the uninsured have family incomes less than twice the federal poverty level and one-third fall below the federal poverty guidelines. These characteristics have an important bearing on the extent to which private insurance can resolve the problem of medical indigence.

- The inadequacy of Medicaid. Although Medicaid is often thought to be the principal means of financing care for the indigent, it now covers less than 40 percent of the poor. Medicaid must now be viewed principally as a program of supplementary coverage for the aged and disabled medically indigent who are eligible for and receive benefits under Medicare. In 1984, barely one quarter of Medicaid's expenditures went to pay for care needed by the non-Medicare eligible poor. Three-quarters of Medicaid's expenditures went to pay for services provided to individuals already covered by Medicare: primary care and other acute care services not covered by Medicare; extended long-term care for Medicare beneficiaries; and Medicare Part B premiums.

- Rapid growth of unsponsored care. At the same time that Medicaid has been providing coverage for a declining percentage of the poor, the amount of uncompensated care provided by hospitals has risen sharply. State and local government tax appropriations have not kept pace with the growth in uncompensated care. Unsponsored care--the care that must be subsidized by the private sector--more than doubled between 1980 and 1984. In 1984 unsponsored care amounted to $5.7 billion or 4.6 percent of total hospital expenses, up from 3.6 percent of total expenses in 1980.

- Declining sources of private subsidy. Traditionally, hospitals have been compelled--and have been able--to subsidize the cost of care provided to the medically indigent by increasing charges to

privately insured patients and patients able to pay their own bills. Between 1980 and 1984, the ability of hospitals to subsidize non-paying patients declined sharply. The principal sources of government financing, Medicare and Medicaid, provide no subsidies for the costs of indigent care. As competitive pressures on private insurers and providers increase, private sources of funds will continue to diminish.

Long-Term Recommendations

Medical indigence is a complex, multi-faceted issue that has no single, or simple, solution. Because the public expects needed care to be provided regardless of a patient's ability to pay, all members of society must participate in the financing of care provided to the medically indigent. This public responsibility does not mean, however, that government alone can or will resolve the problem. An enduring solution to the problem of medical indigence will require initiatives by both the public and private sectors to:

- reduce the size of the medically indigent population through adequate private health insurance; and
- restructure and extend public programs to finance care for the medically indigent who are unable to obtain private insurance.

Private insurance can be made more widely available through the cooperative efforts of federal, state and local government, private insurers, employers, and providers. However, as competition increases and resources become more constrained, a residual public program is essential to finance care for those who cannot obtain private health insurance. To strengthen the public financing of care for the medically indigent, several actions should be pursued:

- The reorganization of Medicaid into three distinct programs: a program of acute care coverage for the medically indigent who are not eligible for Medicare; a program of supplementary acute care coverage for Medicare beneficiaries; and a program of long-term care coverage for Medicare beneficiaries.
- The gradual strengthening of the federal role in funding Medicaid: a Title XIX trust fund sponsored by a properly broadly-based tax, for example a payroll tax. Such a tax could provide a stable source of funding for Medicaid, would equitably distribute the cost of the program, and, properly could create a positive incentive for employers and employees to obtain private health insurance.
- Reform of delivery and payment systems: the adoption of innovative payment and delivery arrangements would encourage the efficient use and production of the health care services needed by individuals enrolled in Medicaid.

Short-Term Initiatives

Although the elements of a long-term solution to the problem of medical indigence can be readily identified, adoption and implementation of a comprehensive solution will take time. It is essential that there be no deterioration of existing programs during these deliberations. Moreover, while the debate over the long-term solution proceeds, the issue should be dealt with through a series of incremental steps which strengthen incentives to provide employer-paid health insurance and gradually strengthen public insurance programs.

Initiatives to Promote Private Insurance

The federal government should strengthen, and not reduce, tax incentives that encourage adequate private insurance.

- Personal income tax incentives: Individuals should be permitted to exclude employer-paid health insurance premiums from taxable income, or to deduct employee-paid health insurance premiums from taxable income, only if the health insurance policy covers all dependents. Current limitations on the tax deductibility of employee-paid health insurance should be rescinded, and the deduction should be made available to all individuals, not just those who itemize deductions.

- Corporate income tax incentives: Health insurance premiums should be deductible as a business expense by employers only if the employer pays for coverage of dependents or offers employees the opportunity to purchase such coverage.

In addition, to address the problems created by the loss of health insurance coverage during periods of temporary unemployment, employers should be required to continue insurance coverage for laid-off workers as part of unemployment compensation.

States should encourage the formation of multiple-employer insurance arrangements in an effort to extend insurance to the self-employed and to employees of small firms.

Private insurers, employers, and providers should work to create innovative financing and delivery systems that increase the availability of affordable insurance, particularly for small employers.

Initiatives to Improve Public and Private Funding

Federal initiatives. Under no circumstances should the federal government reduce the level of federal funding available to state Medicaid programs, nor should it mandate or allow states to reduce entitlement under Medicaid. In addition,

- The expansion of Medicaid eligibility should be accomplished as federal resources permit, with the objective of achieving a uniform standard of eligibility under state Medicaid programs by 1990.

- The federal government should phase in the long term reforms in Medicaid described above, including the creation of a stable, dedicated source of funding.

- To encourage provider participation in Medicaid and to eliminate the need for private sector subsidies of Medicaid expenditures, Medicare and Medicaid payment levels generally should be comparable to those for private patients, that is, the ratio of payments to costs should be approximately the same for public and private payers, although the methods of payment may be different.

State initiatives. States should maintain eligibility and funding levels for Medicaid and other programs designed to finance care for the indigent. As their resources permit, states should expand Medicaid coverage to include both the medically needy and other segments of the medically indigent population.

States should establish risk pools for high-risk or uninsurable individuals. All insurers should participate in such risk pools, including Blue Cross plans, commercial insurers and self-insured businesses. The federal government should facilitate this by modifying the exemption of self-insured employers from state laws regulating the business of insurance.

Local initiatives. Local government should maintain or increase funding for public or other government supported providers. Within metropolitan regions, governments should identify methods of expanding the population base which is responsible for funding public providers. Local government should also evaluate the possible benefits of adopting formally organized systems for delivery of care.

Employer and insurer initiatives. Employers and insurers should work with government to ensure adequate funding for the medically indigent who must rely on public support. If adequate public funding is not made available, employers should work with providers and insurers to establish funding mechanisms for care provided to the medically indigent.

Provider initiatives. Hospitals should maintain their historical commitment to provide care to those who need care, including the indigent; should take appropriate actions to raise public awareness of the implications of purchaser actions for the ability of the hospital to care for the medically indigent; and should work with employers, insurers, and government to develop viable short and long-term solutions to the problem of medical indigence.

REPORTS OF COUNCIL ON MEDICAL SERVICE

The following reports, A–H, were presented by Lonnie R. Bristow, M. D., Chairman:

A. CLOSING THE GAPS IN HEALTH CARE FUNDING: COVERAGE FOR THE PREMIUM INDIGENT

(Reference Committee A, page 308)

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTIONS 19 AND 102

SYNOPSIS

In its Report B at the 1984 Annual Meeting, the Council on Medical Service informed the House of Delegates of the extent of uncompensated care provided by physicians and hospitals. The present report responds to the House request for further study of this general subject by examining a segment of the U. S. population that accounts for a significant proportion of the uncompensated care delivered. This segment is composed of those whose economic status precludes their protection under tax-supported programs, but who find it financially very difficult to purchase adequate health care coverage – or any coverage – in the private sector. It is estimated that this segment comprises from 24 percent to 37 percent of the under 65 population, depending on the criterion used to define "adequate" coverage.

BACKGROUND

In keeping with its interest in issues relating to uncompensated care, the AMA has already studied and developed recommendations to improve the financing of health care for two specific subgroup segments of this population who lack any health insurance coverage under either the private or public sector: the short-term unemployed who have lost employment-based insurance coverage, and those who are uninsurable for medical reasons.

In response to the health insurance problems facing the short-term unemployed, the House adopted Board of Trustees Report NN (A-83). This report, prepared by the Council on Legislation and concurred in by the Council on Medical Service, presented principles and guidelines for a temporary national program to provide health insurance for the unemployed. The Association has developed draft federal legislation to establish such a program for introduction into Congress as soon as the legislative climate appears positive.

In its Report D at the 1983 Interim Meeting, the Council on Medical Service evaluated the feasibility of providing health insurance coverage for the medically uninsurable through state risk-pooling programs, and recommended the development of such programs in each jurisdiction. Also recommended was the development by the Association of model legislation for use by states in establishing or modifying such programs, and modification of the Employee Retirement Income Security Act (ERISA) to allow state regulation or self-insured health plans with respect to requiring their participation in such risk-pooling programs. Since that time, the Council on Legislation has prepared and the Board has approved for introduction into Congress a proposed amendment to effect the necessary change in ERISA; still to be addressed is the development of the recommended model state legislation.

The present report is divided into three sections. The first defines in more detail the entire uninsured and underinsured population, as a percent of the total under 65 civilian U. S. population of 204.9 million in 1983. This group includes the short-term unemployed (and uninsured), the medically uninsurable, and a remaining sizeable segment who – primarily for economic reasons – find it financially very difficult to obtain adequate health care coverage in the private sector, and are either uninsured or underinsured (lack adequate coverage) as a result. They are essentially individuals who are standard risks medically, but

who do not have access to group coverage or adequate group coverage and cannot afford the premium for adequate individual coverage at standard rates. For purposes of this report, they will be termed the "premium indigent." The second section of the report examines the type of health insurance coverage commonly held by the underinsured segment of the "premium indigent." A concluding section identifies the possible policy options for addressing the specific needs of this premium indigent group.

I. SOCIODEMOGRAPHIC CHARACTERISTICS OF THE UNINSURED AND UNDERINSURED

The data used in determining the extent and characteristics of the uninsured were drawn from the 1977 National Medical Care Expenditure Survey (NMCES). This survey included over 190,000 individuals from a nationally representative sample. The data presented below are from a recent study by Farley (1984) using NMCES data. This is the most recent data available for studying the premium indigent. A more recent study by the Bureau of the Census is soon to be released. While the full Census Bureau report is not yet available, preliminary figures relating to the uninsured tend to be consistent with the findings of the Farley study. The NMCES data were adjusted to account for improvements in the catastrophic protection offered by group major medical insurance from 1977 to 1984. In particular, it was assumed that a randomly selected group of 50 percent of individuals with major medical group insurance in 1977 had catastrophic coverage in 1984. In other respects, any inferences about the extent of the uninsured and underinsured in 1984 made from the study depend on Farley's assumption that the distribution of insurance coverage and out-of-pocket expenditures across individuals has remained approximately the same since 1977. Individuals 65 and above were excluded from the Farley study since they are typically covered under Medicare.

THE UNINSURED

The proportion of uninsureds is substantial. About 9 percent of the under 65 population lack any health insurance at all. Another 9.4 percent had no insurance for at least part of the year (as reported in Table 1). Together, these results indicate that 18.4 percent of the under 65 population was without any health insurance for at least part of the year.

As mentioned previously, the AMA has identified and investigated two subgroups of this uninsured population – the short-term unemployed and the medically uninsurable. However, these are not the only subgroups bearing a disproportionately high incidence of no insurance.

Individuals in their early 20s have a disproportionately high incidence of no insurance; thereafter, the fraction of uninsureds declines steadily with age. By sex, females exhibit a substantially higher incidence of no insurance than males. Over 28 percent of women lacked any health insurance for at least part of the year, while this was true for less than 17 percent of males.

Furthermore, while the unemployed had the highest proportion of individuals uninsured for at least part of the year (33.7 percent), part-time employees had the highest proportion of individuals uninsured for all of 1977 (20.1 percent). Lack of insurance is also a problem for self-employed individuals, 23 percent of whom lacked any health insurance for at least part of the year. By contrast, less than 15 percent of full-time employees lacked health insurance for all or part of the year. The evidence suggests that lack of insurance is a serious problem, not only for the unemployed, but for part-time employees and the self-employed.

Not surprisingly, the incidence of lack of insurance also varies by perceived health status. Nearly 23 percent of individuals who considered their health status to be poor were uninsured for at least part of the year, while less than 16 percent of individuals who considered their health status to be excellent were similarly uninsured. This pattern reflects, at least in part, the greater difficulty in obtaining health insurance

that is often encountered by those with a pre-existing illness. In other members of this group, the lack of insurance coverage may be a cause of worsening health – since care is often delayed or not sought at all in this situation.

Lack of insurance varies significantly by family income. While nearly 38 percent of the poor and near-poor lacked any health insurance for at least part of the year, this was true of only 15.1 percent of the middle-income groups, and only 9.8 percent of the high-income group.

Finally, lack of insurance is a more common problem in the South and West relative to other census regions. In the West, 25.1 percent of the individuals lacked health insurance for all or part of the year; the corresponding figure for the South was 23.6 percent. By contrast, the North Central and Northeast regions had lower proportions of individuals without health insurance (13.7 percent and 11.5 percent, respectively). One possible explanation for this pattern is that states located in the Northeast and North Central census regions tend to offer more liberal coverage under Medicaid, so that a larger proportion of marginal income residents of these regions were included under that program.

THE UNDERINSURED

There are no hard-and-fast criteria to use as guidelines in defining and determining the extent of underinsurance. Rather, obtaining estimates of the extent of underinsurance requires that reasonable assumptions be made. First, it must be decided what type of care should be covered by an adequate health insurance policy. A widely accepted principle states that an adequate insurance plan should cover high-cost illnesses. Given this definition, the number of underinsureds may be identified as those individuals who have some private insurance, but who nevertheless may incur large out-of-pocket expenses for major illnesses.

Obviously, what constitutes "large" out-of-pocket expenditures and "non-negligible" probabilities of major illness is subject to varying definitions. One approach is presented by Farley in her 1984 study. She presents three possible alternative criteria for estimating the extent of underinsurance:

> Criterion 1: An individual is considered to be underinsured if there is at least a 5 percent chance that he will incur out-of-pocket expenses for hospital and medical care that amounts to 10 percent or more of his annual income. The number of individuals satisfying this criterion is small.
>
> Criterion 2: An individual is considered to be underinsured if there is at least a 1 percent chance that he will incur out-of-pocket expenses for hospital and medical care that amounts to 10 percent or more of his annual income. The number of individuals satisfying this criterion is larger.
>
> Criterion 3: An individual is considered to be underinsured if his health insurance policy does not include a cap on the amount of out-of-pocket hospital expense he is liable for in the event of a major illness (e. g., the individual lacks catastrophic coverage).* The number of individuals satisfying this criterion is generally the largest, since it defines individuals who have any possibility of incurring large outlays for hospital care as underinsured.

From the health care expenditure patterns actually observed in 1977, Farley was able to determine the probabilities that individuals would incur various out-of-pocket expenditure levels. Under criteria 1 and 2, individuals' expected out-of-pocket expenditures were then compared to their incomes to assess

*Farley did not include limits on expenditures for physician and laboratory services in criterion 3 because hospital bills constitute the bulk of catastrophic health expenses.

TABLE 2

Percent of Total Population Underinsured by Age, Sex, Employment Status, Perceived Health Status, Census Region and Family Income for Each of Three Criteria for Underinsurance

Characteristic	Criterion 1	Criterion 2	Criterion 3
ALL	5.1%	14.1%	18.3%
Age			
Less than 19	3.4	5.9	17.6
19–24	6.5	9.7	13.5
25–34	4.2	7.4	17.0
35–54	4.0	7.8	20.0
55–64	13.7	17.9	24.6
Sex			
Male	4.6	7.8	19.2
Female	7.9	10.6	13.3
Employment Status			
Full-time employee	4.0	6.9	18.0
Part-time employee	7.4	9.3	15.0
Self-employed	7.4	12.0	25.0
Did not work in 1977	8.1	10.9	12.8
Perceived Health Status			
Excellent	3.9	6.9	19.4
Good	5.7	8.9	17.8
Fair	7.9	12.2	16.2
Poor	8.1	11.8	13.1
Census Region			
Northeast	5.3	9.1	23.7
North Central	5.0	7.3	17.4
South	5.5	9.2	18.6
West	4.5	7.5	12.9
Family Income			
Poor and Near Poor	15.0	17.7	10.0
Low	7.7	12.4	17.3
Middle	3.4	7.0	20.6
High	1.9	4.3	19.3

Source: Farley, P.,"Who are the Underinsured," National Health Care Expenditures Study, Washington, D. C., U. S. Department of Health and Human Services, 1984

COMBINED ESTIMATES OF THE UNINSURED AND THE UNDERINSURED

An overall index of the size of the uninsured and underinsured population is provided by combining the separate estimates for percent of the total under 65 population without insurance for all or part of the year with the percent of the insured under 65 population with inadequate coverage under one of the three criteria. The combined estimate depends upon the criterion chosen for underinsurance. Under criterion 1, the most stringent measure of underinsurance, 23.5 percent of the under 65 population were uninsured for all or part of 1977 or lacked adequate coverage (as reported in Table 3). This figure increases to 26.7 percent under criterion 2. Under criterion 3, the most liberal definition of underinsurance, the proportion of individuals with no insurance or inadequate insurance rises to 36.7 percent.

For all three definitions of underinsurance, the types of individuals having the highest estimated levels of no insurance and underinsurance tend to be:

- females;
- part-time employees, the self-employed, and the unemployed;
- those in poor health; and
- those at the lower end of the income spectrum.

II. HEALTH INSURANCE PROVIDERS

It is also interesting to examine the prevalence of underinsurance from the "supply side," i. e., to identify the underinsured by the types of health insurance policies or plans under which they are covered. Underinsurance is a substantially greater problem in nongroup health insurance programs (as reported in Table 4). Some of this variation is due to lower average income of individuals having nongroup insurance; however, evidence also suggests that such nongroup plans provide substantially lower benefits than do group insurance plans.

Examining benefits per enrollee under specific health insurance policies provides further evidence of the variation in coverage across plans. A study by Carroll and Arnett (1981) indicates that, as shown in Table 5, commercial nongroup policy holders had substantially lower hospital benefits paid per enrollee

TABLE 4

Percent of Privately Insured Population Underinsured by Type of Insurance for Each of Three Criteria for Underinsurance

Characteristic	Criterion 1	Criterion 2	Criterion 3
Type of Insurance			
Nongroup	35.8%	51.6%	67.8%
Any Group	5.1	8.6	21.8
25 or fewer members	6.6	13.3	21.2
26-250 members	5.7	9.1	20.0
251-2,500 members	4.1	7.6	24.2
Over 2,500 members	4.5	7.1	21.9

Source: Farley, P., "Who are the Underinsured," National Health Care Expenditures Study, Washington, D. C., U. S. Department of Health and Human Services, 1984

TABLE 6

Percent of Persons with Individual Health Insurance
by Family Income and Employment Status, 1976

Characteristics	Percent
Family Income ($)	
Less than 5,000	18.7%
5,000 to 9,999	13.2
10,000 to 14,999	8.6
15,000 or more	8.2
Employment Status	
Full-Time Wage Earner	5.5
Part-Time Wage Earner	12.4
Unemployed	17.9
Self-Employed	34.5

Source: Profile of Health Care Coverage: The Have and Have Nots, Washington, D. C., Congressional Budget Office 1979

than did group policyholders ($54.85 versus $135.20). Blue Cross/Blue Shield (BC/BS) policyholders had the highest average benefits paid expenditure per enrollee for hospital care. According to the Carroll and Arnett study, about 85 percent of the BC/BS policyholders enrollees were enrolled in group plans. However, average benefit expenditure per enrollee was not reported separately for group and individual BC/BS policyholders in that study. BC/BS benefit expenditures per enrollee in individual plans may be similar to those for commercial nongroup plans.

In addition, in spite of the fact that BC/BS provided higher average benefits for hospital care per enrollee than did independent plans (HMOs, consumer, labor or management sponsored self-insured plans), it does not necessarily follow that independent plans provided less comprehensive coverage for hospital care, since utilization rates tend to be lower for independent plans, as Carroll and Arnett (1981) have noted.

Carroll and Arnett have also noted that independent plans, particularly health maintenance organizations, emphasize first-dollar coverage more often than do either BC/BS or insurance companies. In this connection, Wilensky, Farley and Taylor (1984) have determined that, within employment related group insurance plans, employees who had higher plan premiums did not tend to have more catastrophic insurance than did employees who had lower premiums, but rather higher premiums were associated with more extensive first-dollar coverage. Whether or not coverage for major medical events is equally comprehensive under BC/BS, independent plans or employment-related group plans, this suggests that independent plans and some group plans with first-dollar coverage may be able to contribute to alleviating the problem of premium indigency by substituting "last dollar" coverage for first-dollar coverage.

Clearly, the group most likely to be inadequately insured are the individual policyholders. It is more expensive to provide the same level of benefits to an individual policyholder than employment-related group policyholders. This is due to adverse selection of enrollees in individual health insurance policies, since persons with poor health are more likely to buy health insurance than persons with average or good health, if insurance is not provided by their employer. In order to keep individual policies affordable, some insurance providers have simply kept the benefits provided by these policies at relatively low levels.

coverage more accessible to the self-employed and/or part-time employed, as well as to those not in the labor force. However, adverse selection may become a problem if only the "high users" of health care opt for pool participation. In addition, even risk-pool offerings may not be affordable to those at marginal income levels without special subsidies. Furthermore, methods for assuring participation in such pools by self-funded plans must be found. As noted previously ERISA precludes nearly all state regulation of self-funded health benefit plans; any state legislation which could not require participation in risk pooling by such self-insureds along with other plans might encourage even more employers to self-insure, and thus defeat the idea of risk pooling. Association efforts to address these problems relating to ERISA were identified earlier in this report.

SUMMARY

Based on the Council's study to date, it is clear that the so-called "premium indigent" are a heterogeneous group, and that approaches to improving the accessibility and affordability of adequate health insurance coverage for this population segment must be similarly multifaceted. It is likely that society as a whole already bears the costs attributable to the lack of adequate health care coverage for this group, whether through lost man-hours and productivity or through defraying the economic burden of uncompensated care. The question therefore is not whether such costs should be met, but how they can be met in a way which best maintains and preserves the health of this population group while apportioning this cost equitably over all sectors of the health care economy. The Council will attempt to address this question in a further report to the House of Delegates, and to develop proposals for assuring the availability of adequate health expense coverage for all who need and desire it.

MEMBERSHIP AND ORGANIZATION OF GROUPS

The attached correspondence between Dr. Kettel and Dr. Chapman is self-explanatory.

THE UNIVERSITY OF ARIZONA
HEALTH SCIENCES CENTER
TUCSON, ARIZONA 85724

COLLEGE OF MEDICINE
OFFICE OF THE DEAN
(602) 626-7383

December 15, 1986

John E. Chapman, M.D.
Dean
Vanderbilt University
School of Medicine
Nashville, TN 37232

Dear John:

You raise an interesting point in your correspondence of December 3, 1986. I am well aware of the problems this causes. It is not only in travel to meetings that membership in groups causes, but it is local correspondence, telephone calls and the like.

In years past, the group on medical education established a concept of a single representative who did internal distributions and handled all the correspondence. That person also is a voting member in the group on medical education. They have caucuses and the like before they go to the national meeting and it seems to work very well. I think this deserves some discussion and I will ask Joe Keyes to put it on the agenda for an upcoming Administrative Board meeting.

Thanks very much for alerting me to this problem.

Sincerely,

Louis J. Kettel, M.D.
Dean

LJK/gf

CC: Joseph A. Keyes, Jr.

VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37232 TELEPHONE (615) 322-7311
Dean of Medicine • Direct phone 322-2164

December 3, 1986

Louis J. Kettel. M.D.
Dean, University of Arizona College of Medicine
1501 North Campbell Avenue
Tucson, Arizona 85724

Dear Lou:

Upon updating the various membership directory lists for AAMC groups, sections, and other organized efforts within AAMC, I am finding it a relatively expensive process! The number submitted as members is impressive and seemingly limitless. That looked good inasmuch as awkward and troublesome decisions are avoided, but at the same time, each person represented as "member" expects to have full membership privileges, which includes a paid trip to the meeting. The most direct approach is placing financial limits locally on travel funds. I pass this thought along because other Deans may be in the same position. Would it be advisable to select a designated representative to the meeting and then have others attend as "interested parties to the proceedings"?

With warmest regards,

Sincerely,

John E. Chapman, M.D.
Dean, School of Medicine

JEC/elb

COD SPRING MEETING PROGRAM/THEME DINNER

Following for discussion is a draft copy of the 1987 COD Spring Meeting Program.

A theme dinner has been tentatively scheduled for Monday evening, April 6, since the hotel sponsors a public luau that evening for $38/per person. While the luau will be open to other hotel guests (approximately 75% of the hotel guests will be deans and spouses), the cost is half of what it would cost to reserve a private luau for the deans. A reservation form will be sent to the deans prior to the meeting. Payment is not reuqired until the day of the event.

SPRING MEETING of the COUNCIL OF DEANS

April 5-8, 1987
STOUFFER WAILEA BEACH RESORT
Maui, Hawaii

Sunday, April 5

12:00-4:00 pm

ARRIVAL & REGISTRATION

SESSION I

4:00-5:30 pm

WELCOME & OVERVIEW

PRESIDENT'S REPORT
Robert G. Petersdorf, M.D.

5:30-7:00 pm

RECEPTION

Monday, April 6

SESSION II

8:30-9:00 am

CHALLENGES OF TEACHING PREVENTIVE MEDICINE

Stephen M. Ayres, M.D.
Dean
VCU Medical College of Virginia

9:00-10:30 am

SMALL GROUP DISCUSSIONS

10:30-11:00 am

BREAK

SESSION III

11:00-11:30 am

CONFRONTING THE NEED FOR GERIATRIC EDUCATION

Cecil O. Samuelson, Jr., M.D.
Dean & Professor of Medicine
University of Utah

11:30 am-1:00 pm

SMALL GROUP DISCUSSIONS

1:00 pm

UNSCHEDULED TIME

Tuesday, April 7

SESSION IV

8:30-9:00 am

PHYSICIAN SURPLUS? TRUTH AND CONSEQUENCES

James A. Pittman, Jr., M.D.
Dean & Professor of Physiology
& Professor of Medicine
University of Alabama

Robert H. Waldman, M.D.
Dean & Professor of Internal Medicine
University of Nebraska

9:00-10:30 am

SMALL GROUP DISCUSSIONS

10:30-11:00 am

BREAK

SESSION V

11:00-11:30 am

TRANSITIONITIS: ACTION STEPS

11:30 am-1:00 pm

SMALL GROUP DISCUSSIONS

1:00 pm

UNSCHEDULED TIME

Wednesday, April 8

SESSION VI

8:30-12 noon

COD BUSINESS MEETING

12 Noon

ADJOURNMENT

COD TELEPHONE NETWORK

Dr. Kettel would like to re-establish a mechanism for communication among the deans and with the COD leadership that was initiated several years ago. As you may recall, at the 1985 COD Spring Meeting each member of the COD Administrative Board acted as discussion group leader on issues related to the future of the AAMC. Associated with that assignment, each Board member was encouraged to develop a continuing relationship with the members of his group. Dr. Kettel suggests that this mechanism for enhanced communication among deans which cuts across traditional affinity groups would be profitable to re-establish.

Attached are two groupings of the deans configured to represent maximum geographical and interest heterogeneity. If the Board concurs, we will use these groups for the Maui meeting small group discussions. Additionally, the second of the two groups will represent a continued channel for communication between each small group of deans and a member of the COD Administrative Board. Upon approval, a final printing of the second group, including telephone numbers, will be mailed to each Board member after this meeting.

TELEPHONE NETWORK GROUP # 01

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GROUP LEADER:

Hibbard E. Williams
UC - Davis School of Medicine

DEANS SOCIAL EVENT AT ANNUAL MEETING

The traditional deans reception and dinner at the Annual Meeting has been scheduled for the evening of Monday, November 9th. Attached for further discussions are four proposals for this event. At this time, the staff has tentatively reserved The Phillip Collection for this evening.

THE PHILLIPS COLLECTION

Address: "P" Street, NW
Washington, DC 20036

Reserved:

Monday, November 9, 1987

Council of Deans Reception & Dinner

6:30 pm - Reception throughout exhibit areas

7:30 pm - Dinner/white glove dinner in the music & sitting rooms of the Collection

9:30 pm - Following Dinner/coffee & cordials served throughout exhibit areas

*Musical Entertainment: options listed below

Costs:

Rental of Phillips Collection - $5,000/inclusive of security

Caterer: provided by Design Cuisine
- menu & prices based on selections (will provide menus based on price limitations in June, 1987)

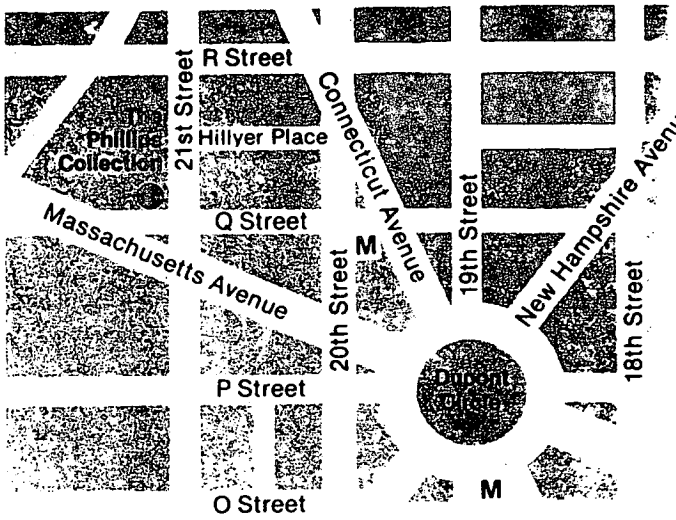
Musical Options:

Strolling Strings - $2,150 w/ Michael Ryan (baritone soloist w/ President's own Marine Corps Band)

Pianist: $250/evening

String Quartet - $650/evening

Harp and Flute - $500/evening



The Phillips Collection

1600-1612 21st Street NW, Washington, D.C. 20009-1090
(202)387-2151, (202)387-0961 Visitor Information Recording

Admission by Contribution

Museum Hours Tuesdays through Saturdays 10 am to 5 pm; Sundays 2 to 7 pm. Closed Mondays, New Year's Day, the Fourth of July, Thanksgiving and Christmas.

Tours of the Museum Introductory tours of the Collection are offered free of charge on Wednesdays and Saturdays at 2 pm. Special Group Tours and Orientation Talks are available by appointment for a nominal fee. Reservations should be made at least one month in advance by calling the Education Office at (202) 232-8403.

Suzanne's Café at The Phillips Collection Lunch and light fare, Tuesdays through Saturdays 10 am to 4 pm, Sundays 2 to 4:30 pm. Tours and groups contact (202) 483-7779.

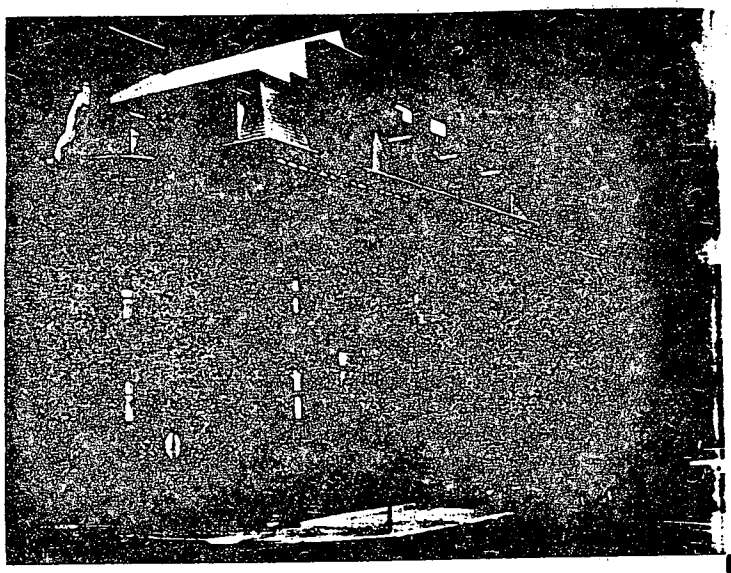
Concerts Sunday afternoons at 5 pm, September through May. No concert Easter Sunday. Admission is free, seating is unreserved. Early arrival is recommended.

Photography Photography of loan exhibitions is not permitted. Photography of the permanent collection, taken in existing light, is permitted. Flashes and tripods are prohibited.

Museum Shop A large variety of postcards, notecards, reproductions, catalogues, books, slides and items related to the museum's collection are available in the museum shop at 1612 21st Street. Shop hours are 10 am to 4:30 pm Tuesdays through Saturdays and 2 to 6:30 pm on Sundays.

Public Transportation to the Museum Metrorail: The Phillips Collection is located one block west of the Dupont Circle Metro at Q Street on the red line.

Metrobus: G-2 crosstown via P Street; N2, N4 local via Massachusetts Avenue; 42, 46 local via Connecticut Avenue; L2 via Connecticut Avenue to the District line.



LATE IN THE FALL OF 1921, two large rooms of a private home near Dupont Circle were quietly opened to the public of Washington, D.C. On the walls were paintings by Chardin, Monet, Sisley, Monticelli, and Fantin-Latour. Along with them were works by the contemporary Americans Twachtman, Weir, Ryder, Davies, Whistler, Lawson, Luks, and Hassam.

This was the opening of the Phillips Memorial Art Gallery, now known as The Phillips Collection, the first museum of modern art in the United States.

The Collection was launched in 1918 by Duncan Phillips (1886-1966), grandson of a founder of the Jones and Laughlin Steel Company, in memory of his father and brother, who had died within thirteen months of each other. Phillips conceived of his museum "as a memorial, a beneficent force in the community where I live, a joy-giving, life-enhancing influence, assisting people to see beautifully as true artists see."

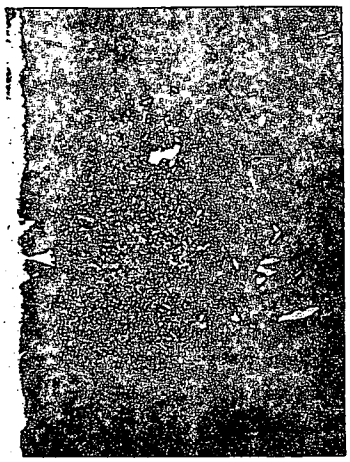
Building on a small family collection, Duncan Phillips amassed some 240 paintings between 1918 and the public opening in 1921. A few weeks before the opening he married Marjorie Acker, herself a painter, and with her help personally selected and gave to the museum most of the 2,500 works it now contains.

In the 1920s the Collection grew at a remarkable rate—Renoir's *The Luncheon of the Boating Party* was acquired in 1923 for the now unbelievably low price of $125,000 (but a record for its time), Daumier's *The Uprising* in 1925, and Cézanne's *Mont Sainte-Victoire* in 1925. In 1930, when the Collection had grown to 600 paintings, the Phillips family moved out of the house and renovated it for use as a museum. An extensive new wing was built in 1960 to accommodate the further growth of the Collection.

Duncan Phillips bought art, not necessarily because it was widely acclaimed, historically significant, or radically innovative, but because it impressed him as a beautiful product of a particular artist's unique vision. His increasingly catholic taste excluded the academic and faddist, but honored "the lonely artist in quest of beauty, the artist backed by no political influence or professional organization."

Phillips also believed strongly in the continuous tradition of art, calling the Collection "a museum of modern art and its sources" and collecting such past masters as El Greco because he was "the first impassioned expressionist," Chardin because he was "in a sense that all painters understand, the first modern painter," and Manet for "the pictorial in full flat light." Collection units were rapidly formed of some of Phillips's favorite artists: Bonnard, Braque, Cézanne, Daumier, Klee, Ryder, and Twachtman.

Meanwhile, during the 1920s, Duncan and Marjorie Phillips became enthusiastic patrons of certain American Modernists, starting with John Marin, Georgia O'Keeffe, Marsden Hartley, and Arthur Dove. Phillips was the first important collector of Dove's work and his foremost patron for twenty years. Similarly his support of Augustus Tack



and Karl Knaths proved crucial to their artistic careers. Phillips was the first museum director to show or collect the work of Milton Avery.

In addition to serving as a collector and museum director, Duncan Phillips became widely respected as a writer and lecturer on art. He is the author of numerous books and magazine articles on collecting art and critical essays on artists ranging from Giorgione to Rothko.

When Phillips died in 1966 he was succeeded as director by his wife Marjorie, who celebrated the museum's 50th anniversary in 1971 with an extraordinary international loan show of the works of Paul Cézanne and the publication of her biography of Duncan Phillips. Their son, Laughlin, who became director in 1972, has been concerned principally with insuring the physical and financial security of the Collection.

THE MUSEUM TODAY

Duncan Phillips wanted his successors to keep the Collection alive by frequent rearrangements of the permanent collection, occasional important acquisitions, a series of loan exhibitions, and continuation of the free Sunday afternoon concerts initiated in 1941. However, he was satisfied that the Collection had "attained to its essential character as a home for a wide diversity of paintings, with a unity in all the diversity, and as an intimate personal creation," and he wanted that character to be maintained.

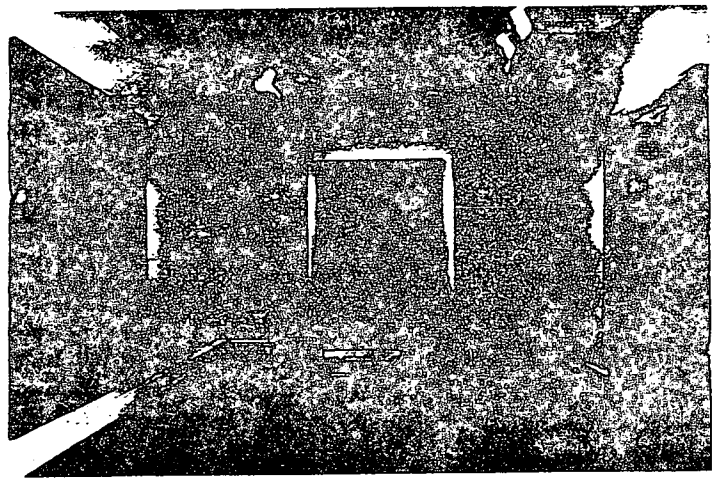
Care and Display of the Permanent Collection

Renovations to the Collection's original building during 1983-84 included completely new electrical wiring and climate-control systems; new lighting, audio-visual, and handicapped-access systems; the refurbishment of the Music Room; the establishment of kitchen facilities and a café; and several new offices to house the museum's expanded staff.

The final phase of the museum's renovation program calls for the creation in the annex of badly-needed storage and picture-handling spaces. Equally important will be the provision of a special suite of galleries on the third floor for temporary exhibitions. The creation of these galleries will allow the museum to continue the important program of temporary exhibitions while also displaying up to 100 more works from its permanent collection. The renovations will also provide additional administrative offices on the fourth floor, an expanded museum shop, and facilities for membership activities. Finally, the facade of the new wing will be made more compatible with the Georgian Revival architecture of the museum's original building.

Temporary Exhibitions

The Phillips Collection organizes approximately six to eight temporary exhibitions each year, including many which travel to other museums in this country and abroad. Recent traveling exhibitions organized by The Phillips Collection include *Franz Kline: The Color Abstractions* (1979), *Arthur Dove and Duncan Phillips: Artist and Patron* (1981), *Georges Braque: The Late Paintings 1940—1963* (1982), *Morris Graves: Vision of the Inner Eye* (1983), and *Pierre Bonnard: The Late Paintings* (1984).



Education

As part of his plan to use the Collection for educational purposes, Duncan Phillips presented an active lecture program, as well as a concert series designed to demonstrate the interrelation of the arts. An art school offering classes in studio methods was active at the museum in the 1930s and 40s. An education office, established in the fall of 1985, will provide an expanded program of specialized gallery talks, tours, and lectures, as well as classes held in conjunction with other Washington museums and universities.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

November 9, 1987

7:00 p.m. - 10:00 p.m.

OPTION II
RECEPTION AND DINNER AT
THE CONGRESSIONAL CLUB

Leave the hotel by motor coaches for The Congressional Club, a private club for wives of members of the House, Senate, Supreme Court and Cabinet. Rich in history and tradition, the Club is bipartisan in nature and represents every section of the country. A magnificent doll collection from all over the world has been presented to the Club by foreign countries. Also displayed are figures of famous First Ladies in the gowns they wore at their particular Inaugural Ball.

Following cocktails and hors d'oeuvres in the beautiful downstairs rooms, dinner will be served in the elegant Grand Ballroom.

Hors d'oeuvres to be passed: Fried Wontons
Miniature Egg Rolls
Spinach/Cheese Balls

* * * *

Prosciutto and Melon

Filet Mignon with Mushroom Cap
Bearnaise Sauce

Chateau Potatoes
Broccoli with Hollandaise Sauce

Spinach Salad served with Brie Cheese

Hot Rolls and Butter

* * * *

English Trifle de La Terra*

Coffee/Wine

*The "Surprise Dessert" will be a silver flower pot filled with English Trifle and covered with shaved chocolate. Fresh, brightly colored flowers will be "planted" in each pot. After the dinner plates have been cleared, the waiters will serve the Trifle with a garden trowel, to each guest.

Some musical suggestions are:

Pianist during cocktails and dinner
The Strolling Strings

The Strolling Strings is a unique, musical ensemble that entertains regularly at the White House. Following dinner, a narrator and ten fine musicians will take you "Around the World" with an outstanding performance of beautiful string music. The forty minute show features selections from Dr. Zhivago, Fiddler on the Roof, The Sound of Music, My Fair Lady, and many more international favorites. Michael Ryan, baritone soloist of "The President's Own" Marine Corps Band will accompany the group as the narrator/singer.

Menu cards using the picture of the enclosed sketch of the Congressional Club would be nice at each place setting, or it could be used as an invitation if you are sending them.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Cost Estimate

Club Rental	$1,500.00
Food, Equipment, Personnel, Liquor and flowers @ $80.00 per person	
Music	
Pianist	$ 250.00
Strolling Strings	$2,150.00
Flowers @ $45.00 per table arrangement	
Transportation @ $235.00 per bus	
Washington, Inc. Fee	$1,500.00
Menu Cards - Estimate	$350.00 - $400.00

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Monday, November 9, 1987

7:00 p.m. - 10:00 p.m.

OPTION III
RECEPTION AND DINNER
AT THE STATE DEPARTMENT¶

The Diplomatic Reception Rooms at the State Department are considered to be among the most beautiful in America. "Project Americana" was initiated in 1961 for the purpose of furnishing these rooms with the finest in American period furniture, original oil paintings and examples of the decorative arts of the period 1740-1825.

The John Quincy Adams State Drawing Room is furnished in the Chippendale style. Prominently displayed is the Treaty of Paris desk on which the final treaty of Paris which ended the American Revolution was signed.

Cocktails and hors d'oeuvres will be in the Jefferson Reception Room which reflects the 18th Century Palladian characteristics so admired by Mr. Jefferson. The balcony offers a spectacular view of the Capital's skyline.

Dinner will be served in the Benjamin Franklin State Dining Room, which has recently been re-designed in the classical manner of the 1790's. Linens and flowers will be in keeping with the Federal decor.

Music for the evening will be provided by a string quartet during cocktails and following dinner, The Capital Chorale (the Navy Sea Chanters moonlighting in Black Tie) will present a rousing program of songs of our heritage from the Revolutionary War through the Civil and World Wars to the Present. If you prefer, they will offer a program of Popular or Broadway songs.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUGGESTED MENU

Lobster Quenelles
Sauce Nantua

Mignons of Veal
Sauce Morel

Artichoke Bottoms
with Tricolor Tortellini

Vegetable Bouquet

Endive and Mushroom Salad
Raspberry Vinaigrette

Brie with Pistachio

Creme Marie Antoinette

Coffee

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Cost Estimate

Donation to the State Department	$25,000.00
Support costs - Estimate	$ 2,000.00
Food, Equipment and Personnel @ $115.00 per person	
Liquor, Wine, Liquers @ $15.00 per person	
Flowers @ $55.00 per table	
Music	
String Quartet	$ 650.00
Capitol Chorale	$ 2,500.00
Transportation @ $235.00 per bus	
Washington, Inc. Fee	$ 1,500.00

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

November 9, 1987

7:00 p.m. - 10:00 p.m.

OPTION IV
RECEPTION AND DINNER AT
CORCORAN GALLERY OF ART

Chartered buses will depart the hotel between 6:30 and 7:00 p.m. for the Corcoran Gallery of Art, the beautiful neo-classic building housing a comprehensive collection of American painting from colonial times through the 19th century - genre, still-life, landscapes, the realists and impressionists. The Corcoran, located adjacent to the White House and the Executive Office Building, was founded in 1869 - the first art gallery in the nation's capital. It houses, also, an excellent and representative group of European works.

As guests enter the gallery, fourteen string instruments will be assembled at the side of the marble stairway and will continue to play throughout the reception. They will present the "Around the World" show with Michael Ryan following dinner.

Linens and floral arrangements will complement the Fall theme. Dinner will be served in the Atrium and there will be cocktails and hors d'oeuvres offered at the Bridge at the head of the Grand Staircase proceeding dinner.

SUGGESTED MENU

Hors d'oeuvres to be passed:

Apricots Wrapped in Bacon

Bouchess Plumped with Brandied Pate

Artichoke and Parmesan in Flaky Pastry

* * * *

Sole Florentine
Beurre Blanc Sauce
Fleurons

* * * *

Roast Loin of Veal
Pistachio Sauce
Yellow Squash Boats Filled with
Piemontaise Rice and Spinach
Broccoli Spears in Orange Shallot Butter
Parsley Bread

* * * *

Salad of Boston Lettuce with Watercress,
Sliced Avocado and Grapefruit Sections
Dijon Vinaigrette
Camembert Mousse
Oat Biscuits

* * * *

Apple Charlotte
with Crushed Raspberry Sauce
French Roasted Coffee
Cream
Sugar
Tea
Sanka

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Cost Estimate

Donation to the Corcoran Gallery of Art	$7,500.00
Support Costs	$ 550.00
Food, Equipment and Personnel @ $112.00 per person	
Liquor, Wine and Liquers @ $15.00 per person	
Music	
Strings on Stairs	$1,650.00
Strolling Strings Show	$2,150.00
Flowers @ $50.00 per table	
Transportation @ $235.00 per bus	
Washington, Inc. Fee	$1,500.00

FUTURE MEETING DATES

1987 Meeting Dates:

Executive Council/COD Admn. Board -

April 15-16
June 17-18
September 9-10

AAMC Annual Meeting -

November 7-12
Washington Hilton Hotel
Washington, DC

COD Spring Meeting -

April 5-8
Stouffer Wailea Beach Resort
Maui, Hawai'i