



**Association of American
Medical Colleges**

**COUNCIL OF DEANS
SPRING MEETING**

PROGRAM

**PREPARING THE PHYSICIAN
OF THE FUTURE**

**April 9-12, 1980
Hilton Inn and Conference Center
at Inverrary
Fort Lauderdale, Florida**

**1980 SPRING MEETING OF
THE COUNCIL OF DEANS**

**April 9-12, 1980
Fort Lauderdale, Florida**

**PREPARING THE PHYSICIAN
OF THE FUTURE**

PROGRAM

Wednesday, April 9

1:00 p.m.- ARRIVAL & *Lobby*
5:00 p.m. REGISTRATION

SESSION I

5:30 p.m.- WELCOME & PRELUDE *Biscayne-*
7:00 p.m. TO COD BUSINESS *Inverrary*
MEETING *Room*

7:00 p.m.- RECEPTION *Poolside*
8:30 p.m. TO WELCOME NEW DEANS
AND THEIR SPOUSES

Hosted by: University of Florida
College of Medicine
University of Miami
School of Medicine
University of South Florida
School of Medicine

Thursday, April 10

SESSION II

8:30 a.m.- *Biscayne/Inverrary*
10:30 a.m. *Room*

**THE FUTURE PHYSICIAN: REASONABLE
EXPECTATIONS AND CURRICULAR NEEDS**

—Jeremiah A. Barondess, M.D.
President, American College of
Physicians
Clinical Professor of Medicine,
Cornell University Medical College

**MEDICAL SCHOOL EDUCATION 1975-1979;
A STUDENT'S PERSPECTIVE**

—Ludwig Eichna, M.D.
Former Chairman, Department of Medi-
cine, SUNY-Downstate
Medical Student, Downstate Medical
Center, 1975-1979

10:30 a.m.- BREAK
11:00 a.m.

SESSION III

11:00 a.m.- *Biscayne/Inverrary*
1:00 p.m. *Room*

**THE NEW BIOLOGY AND THE FUTURE OF
MEDICAL EDUCATION**

—David M. Kipnis, M.D.
Chairman, Department of Medicine,
Washington University

**INFORMATION HANDLING: A WORKING MODEL
AND FUTURE PROSPECTS**

—Jack D. Myers, M.D.
University Professor, (Medicine)
University of Pittsburgh

1:00 p.m.- UNSCHEDULED TIME

Friday, April 11

SESSION IV

8:30 a.m.- *Biscayne/Inverrary*
10:30 a.m. *Room*

**VISIONS OF THE FUTURE—
AN EXTRA-SCIENTIFIC PERSPECTIVE ON THE
CONTEXT OF MEDICAL EDUCATION**

—Charles Fried, Esq.
Professor of Law, Harvard University

**THE ACADEMIC PREPARATION OF CANDIDATES
FOR MEDICINE**

—Rudolph H. Weingartner, Ph.D.
Dean, College of Arts and Sciences,
Northwestern University
—Thomas H. Meikle, Jr., M.D.
Assistant to the President, The Macy
Foundation

10:30 a.m.- BREAK
11:00 a.m.

SESSION V

11:00 a.m.- *Biscayne/Inverrary*
1:00 p.m. *Room*

ARE CHANGES CALLED FOR?

—General Discussion

1:00 p.m.- UNSCHEDULED TIME

Saturday, April 12

SESSION VI

8:30 a.m.- COD BUSINESS *Biscayne-*
12 Noon MEETING *Inverrary*
Room

12 Noon ADJOURNMENT



**association of american
medical colleges**

**AGENDA
FOR
COUNCIL OF DEANS**

SPRING BUSINESS MEETING

SESSION I

WEDNESDAY, APRIL 9, 1980

5:30 P.M. - 7:00 P.M.

SESSION II

SATURDAY, APRIL 12, 1980

8:30 A.M. - 12 NOON

**BISCAYNE/INVERRARY ROOM
HILTON INN & CONFERENCE CENTER AT INVERRARY
FORT LAUDERDALE, FLORIDA**

FUTURE MEETING DATES

AAMC ANNUAL MEETING-----October 25-30, 1980
Washington Hilton Hotel
Washington, D.C.

1981 COD SPRING MEETING-----March 29-April 1, 1981
The Broadmoor
Colorado Springs, Colorado

COUNCIL OF DEANS
SPRING BUSINESS MEETING
Biscayne/Inverrary Room
Hilton Inn & Conference Center at Inverrary
Ft. Lauderdale, Florida

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STATEMENT OF UNIVERSITY PRESIDENTS CONCERNING
FEDERAL HEALTH PROFESSIONS EDUCATION PROGRAMS

We as presidents and chancellors have a special responsibility to be concerned about the integrity of universities and the institutional values that have led to a system of high quality education and extraordinary productivity in research. We are grateful to be part of the federal-university partnership in education for the health professions and in health-related research that has produced so many benefits. We are concerned, however, that some provisions of previous federal health education programs have eroded the autonomy and independence of our institutions. Threats to institutional integrity are properly a concern for boards of trustees and regents as well as for presidents, deans and faculty. We believe that all who are working on behalf of universities should be sensitive to these matters.

Three factors make health-related institutions particularly vulnerable to manipulation and loss of autonomy. First, while the sense of urgency surrounding health care problems makes it desirable for society to act, the great complexity and expense of the modern health "industry" make most simple actions problematic at best. As a result, it is natural to turn to the educational system in the hope of effecting long-range change at minimal cost. Second, because of rapidly rising costs and expanded missions, many schools which provide health education have become dependent on the federal government not only for research funds but also for flexible core operating money. Third, because a significant portion of health science education is conducted in a teaching hospital patient care setting which involves the federal government as a prime payor, universities have added dependency on government through these essential patient service programs. Accordingly, universities with health centers are highly susceptible to federal control and influence through funding mechanisms.

Weakening of independence is not necessary if proper care is taken. There is ample precedent for satisfactory relations between the federal government and universities. For most of its thirty-plus years of operations, the federal-university partnership in biomedical research has been a model envied by other nations. The federal government has set general directions and guidelines in fields of research promise. Specific goals and plans were developed by academic personnel and submitted to an intensive competitive process to determine which plan best justified the expenditure of federal dollars. In the process, unbiased experts in a specific area stressed quality and relevance to ensure the objective being accomplished was the finest achievable result. With the recognition that project grants alone were insufficient for maximal research output, provisions were made through another grant program, the Biomedical Research Support Grants, to provide a considerably smaller but significant amount of flexible funds to undergird the institution's overall research program as a means of furthering the public purpose. Total management responsibility was delegated to the university with periodic review by federal agents. Thus, a system was evolved to ensure competitive selection of the best research, autonomy and independence in its conduct, and fiscal accountability for the funds utilized. The integrity of the partners was inviolate.

The partnership in health education is more difficult to manage than that in health research, primarily because education deals with activities that involve an entire institution rather than a smaller sharply defined effort by a single investigator or a small team. As we grope toward more satisfactory legislation and regulations, universities must be vigilant to resist intrusions into:

- faculty hiring, retention and promotion, including determination of the proper specialty mix of faculty;
- curricula, including decisions about what courses will and will not be taught, who will teach them, how they will be taught, when and where they will be taught, and what their content will be;
- admissions, including which individuals will be admitted and what the requirements will be;
- examinations, grading and the requirements for promotion and graduation;
- internal administrative structure.

(Employment and admission policies will, of course, be carried out under federal guidelines for equity and affirmative action.)

Defining the proper relationship between universities and the federal government can never be easy. For example, federal grants for starting new courses deemed in the national interest are a proper and helpful way to permit health schools to meet national needs; however, even here care must be exercised. An offer to fund curricular changes coupled with a decrease in federal support for operating budgets could apply great financial pressure which might place institutional leadership between the horns of a dilemma: either accept disruption in health education programs or accede to federal funding which compromises institutional integrity. Such a choice is most unfortunate.

Solutions will not be easy. Sensitivity and restraint on the part of the federal government continue to be required. Universities and their components engaged in health education must be accountable for the use of public funds and responsive to the nation's needs, but also must stand firm in protecting their integrity. Maintaining institutional strength is as important as federal restraint.

We believe also that the tone of public discussion of these issues is important. Universities and those speaking for them must at all times supply the public with honest and trustworthy information. Our institutions will be in existence for many years. It is important that we maintain a reputation for credibility with government officials, with the general public and within our own communities. We must guard against extravagant claims or promises which may raise false hopes. We must guard also against institutional selfishness any tendencies toward self-serving redirection of public funds entrusted to us. As discussion progresses, it is important that full communication be maintained within our universities between those with responsibility for the institution as a whole and those with responsibility for administration of a component of the university engaged in the education of health professionals. National agencies which serve the interests of the schools and faculties of the universities must be made aware of the importance of institutional integrity.

We are optimistic about reaching satisfactory solutions. Our democracy has flourished because problems have been solved by various combinations of public and private actions. We face the challenges of health education and the provision of health care with hope and in the conviction that our institutions will continue to play an important role without further jeopardizing that institutional freedom which is indispensable to the most productive pursuit of teaching and research.

Adopted by the Association of American Universities, American Council on Education and the National Association of State Universities and Land Grant Colleges.

THE STABILIZATION OF RESEARCH GRANT SUPPORT

The Problem

On page 1 of the formal "Justifications" submitted to the Congress by the DHEW in support of the President's FY 1981 Budget request for the NIH, the following statement appears.

"The 1981 budget reflects a substantial shift in emphasis among the mechanisms of research support. Of major importance is the continued adequate support of the science base in order to carry out the NIH mission. The NIH has concluded that the best investment of the research dollar is in research project grants (investigator-initiated grants), the primary instrument for breakthrough in the basic research area. This decision is reflected in the allocation of 1981 fund. We will place major emphasis on funding approximately 5000 competing research project grants; with the goal of achieving a balance between non-competing and competing awards. Such a balance will allow a critical stabilization of support for the research community and provide for the infusion of new ideas. The other mechanisms of support, such as intramural research, training, contracts and research centers programs are among the areas which will remain level or slightly below the 1980 level of effort in 1981."

This officially surfaces a proposal that has been incubating for some time and that has been discussed by the Director of NIH with his Advisory Council over the last six months.

Background

"Stability" is a many-splendored coat, whose meaning is as often in the eye of the beholder as in reality. The Association should give some thought to the question of whether this specific proposal warrants support.

More than twenty years ago, the then Director, NIH, Dr. James A. Shannon commented that, if the NIH were to distribute public funds for biomedical research to private sector institutions on the principle that only the most worthy projects, as determined through national competition by scientific peers should be rewarded, then the only stability that could be offered was "stability of opportunity". Thus, in Shannon's view, competition foreclosed any expectation that individual scientists might entertain for stable funding and assured research oriented institutions only the net or average stability probable if a large enough number of their faculty members participated in the national competition.

Recognizing that unsuccessful competitors in the contest and the institutions with which they were affiliated are thereby confronted with an acute financial crisis, the NIH viewed as legitimate the use of biomedical science support (formerly, general research support) grant funds as a temporary cushion to blunt the impact of such set backs.

The scientific community has long subscribed devoutly to this basic principle on which the NIH has relied in the distribution of funds and Shannon's deductive inference on the consequences seems unexceptionable. The issues, then, seem to reduce to the question of how best to "stabilize opportunity." The current administration of the NIH seems to have selected the expedient of attempting to secure a "lifetime guarantee" from the Administration and the Congress, that each year, funds for approximately 5000 competing (new and competing renewal) ROI and POI project grants will be appropriated. This number was calculated to be the annual additions necessary to maintain a steady state pool of grants of approximately the present size, turning over with an average project period length of about 3.3 years. Apparently a pact has been negotiated with the OMB and the first "Test run" before the Congress will be taken in the FY 1981 appropriations request.

Until the present, no specific mechanism for achieving stability of any character has ever been formally proposed. Executive Branch requests have taken into account the number, size and expected quality of a known fact---the competing renewal grant applications expected to be filed---, and have attempted to estimate an unknown---the amounts needed to fund some arbitrary fraction of new applications. The formal and official outcome of Executive Branch analyses is a series of Presidential Budget requests that increase those of the previous year only modestly, if at all. The scientific community tended to focus on the relatively small fraction of the approved grant requests that were funded, to emphasize the large number of approved but unfunded applications and to advocate strongly that funds sufficient to compensate for inflation and to make a dent in this backlog be appreciated. When successful in the latter effort, the following years' pool of non-competing grants is increased, a reality that precipitates a new crisis for the next cohort of competing applications.

The debate about stability has focused on "yo-yo" effects, on the government giving with one hand and taking away with the other, on the inability of scientists and administration to predict the level of research funding, etc. Looked at in the aggregate, however, the Federal commitment over the last twenty years has been remarkably steady: a steady rise from 1960-1968, followed by a much slower one---or virtually none at all, if measured in constant dollars---from 1968 to the present. Aggregated data can obscure severe oscillations in specific small program areas, but examples of such cannot be frequently or easily identified. More impressive, it seems to the AAMC staff, is the failure of Federal Agencies to provide research funding for a more significant fraction of the expanding pool of scientists that are ready, willing and able to try to exploit the unnumberable opportunities to extend the current knowledge base.

What sort of stability does the NIH proposal promise to the biomedical research community? This is not clear to the staff of the AAMC.

- No fixed number of awards or awardees, or no pool size of investigators seems ideal, especially in a universe in which both the talent and the opportunities are proliferating rapidly. Why not 3000? or 7000?
- The proposal does not guarantee full funding of the awards. Historically, the most difficult parameter to modify has been funding, with a tendency for the Administration to hold constant the amount requested for the sum of competing and non-competing awards, and recently, for the Congress to follow suit. The 5000 awards could turn out to be hollow stability if, as is not unlikely, the OMB viewed itself honoring its solemn commitment, even if an average fund reduction of 20% had to be absorbed within this pool of awards.
- It is not clear whether approximately 5000 competing awards per year is intended to be a floor or ceiling. The fact that it emerges in the context of stabilization suggests that it is intended to be a floor, unless the objective is to freeze the enterprise at that level in perpetuity. However, history is replete with ceilings that started out as floors. In point of fact, it is curious that the number of competing ROI's and POI's awarded, respectively, in Fiscal Years 1977, 1978, and 1979 were 3840, 5200, and 5937. This suggests that 5000 has become a ceiling rather than a floor even before it has been fully born. For each of these years, by the way, the comparable approved but unfunded number of grants were 7062, 7508 and 6815.
- Another question that arises is the price to be paid for stability, especially when viewed narrowly as in the case of ROI's/POI's. It is likely to become an exercise in legerdemain, with the transfer of funds from non-stabilized into stabilized accounts. One might wonder whether the failure of the President to request one single dollar for competing training awards for any of the institutes in the FY 81 budget submission was an example of this process.

The AAMC staff has experienced a great deal of dis-ease about the appropriate position to take on the NIH/Administration to "stabilize" the number of competing ROI and POI grants annually awarded by the Institutes. The dilemma relates to the fact that stabilization probably carries a connotation in the general constituency akin to that of Flag, apple pie, yesteryear, and motherhood. Yet the proposal to achieve it looks more like a straitjacket than anything else.

Question for discussion

What should be the Association formal position on the proposal to stabilize the number of ROI and POI grants awarded by the NIH at the level of 5000/year, when testimony is presented to the House and Senate appropriations Committees?

H.R. 6522, THE HEALTH RESEARCH ACT OF 1980

On February 13, Representative Henry A. Waxman (D-CA), introduced H.R. 6522, the "Health Research Act of 1980", a bill designed to revise Title IV of the Public Health Service Act. The bill is also being sponsored by Representatives Tim L. Carter (R-KY); Doug Walgren (D-PA); Phil Gramm (D-TX); and Mickey Leland (D-TX).

The bill is 78 pages in length and contains many provisions the most important of which are summarized below:

- a) The bill proposes to establish limited authorities and expenditure ceilings for each of the Institutes. Thus, the permanent authorities and open-ended appropriation ceilings under which most of the Institutes currently operate would be revoked. Both the National Cancer Institute and the National Heart, Lung and Blood Institutes lost these in 1971 and 1972 respectively. AAMC is particularly concerned about these changes because short-term authorities are ill-suited to the rapidly changing nature of scientific research. The perennial problems facing short-term authorities---crowded legislative agendas combined with renewal deadlines---could seriously disrupt research activities.
- b) H.R. 6522 proposes to require peer review on a project by project basis for all intramural research. Such a requirement could have an adverse impact on the NIH intramural programs by imposing the same peer review requirements extramural grantees must contend with on intramural scientists. Given the fact that one of the few attractive features of doing research at NIH is that the labor of preparing grant applications is avoided now, such a requirement seems inappropriate. Moreover, intramural scientists and their research must currently undergo careful scrutiny (peer review) by boards of Scientific Counselors and intramural supervisors.
- c) The bill appears to establish an identical pattern of review for research contracts and for research grants. Contracts receive equally intense review as grants prior to funding but contracts generally procure products, materials or are used to support clinical trials, etc. for which the grant-in-aid is inappropriate. Also, the manner in which bids are taken and contracts awarded is prescribed by law. Therefore, requiring that the review of contracts be identical to the review of research grants seems inappropriate and should require further study. Council review of contracts on an

individual basis would add seriously to the council workloads with little advantage and is contrary to the well-researched conclusion of the 1967 Ruina Committee.

Aside from these major areas of concern the Association believes that the bill does contain one overriding imperative---the renewal of authorities affecting the Cancer, Heart and Arthritis Institutes, and the appropriation ceilings for the first two are too low. Unless these programs are renewed promptly, serious disruptions could occur in the planning and conduct of important research.

The Association is in basic agreement with the following provisions:

- d) **Payback:** Exempts first-year trainees from payback obligation if they decide not to pursue research training beyond the one year. This provision diminishes the punitive aspects of the payback provision which have in the past deterred physicians who are interested in pursuing a research career but are not certain whether they are personally suited for or talented in clinical research. We would prefer complete elimination of the first payback year.
- e) **Flexibility in Establishing/Disestablishing Institutes:** H.R. 6522 provides the authority for the Secretary to establish additional research institutes, disestablish existing institutes, and shift the functions of institutes as deemed necessary. This provision would provide the necessary flexibility to organize research institutes in the most logical and meaningful manner based upon continual advances and changes in scientific knowledge.
- f) **Authority to Establish Peer Review Bodies:** H.R. 6522 provides the Director of NIH the authority to establish peer review bodies. The peer review system has suffered a great deal of stress in recent years because of work overload on existing peer review bodies. This provision would permit the Director to alleviate much of the current stress which is threatening the peer review system.
- g) **Exemption of Research Grants under \$50,000:** Currently, research projects of \$35,000 or less in direct costs may be funded without advisory council review. H.R. 6522 would increase to \$50,000 those research projects that may be funded without Council review. With rising costs due to inflation this provision brings the former \$35,000 cutoff to a more realistic level and alleviates unnecessary burden on advisory councils.
- h) **Uniformity Among Institutes:** In general, it is logical and appropriate to bring all Institutes under the same Act and eliminate many of the inconsistencies among Institutes. NCI and NHLBI have been dealt with as separate entities in statute, and there is no compelling reason for this fragmentation. All research Institutes of NIH should be treated uniformly.

H.R. 6522 is a "companion" to Title II of S. 988, a bill which is awaiting mark-up in the Seante. H.R. 6522 contains no provisions at this time for a National Health Advisory Council or paperwork reduction experiments (Titles I and III of S. 988).

Hearings on the bill were held on February 21, 25, 29 and March 3; Dr. Robert W. Berliner testified on the Association's behalf on the 29th. The AAMC statement emphasized the three major areas of concern cited above. The proposed legislation appears to be on a "fast-track" with mark-up expected by March 15. This situation is in part due to the necessity to renew authorities for the Cancer and Heart, Lung and Blood Institutes before May 1 so that appropriations can be made by September 30. One proposal which has merit is that these authorities be renewed by themselves and that H.R. 6522 and S. 988 be considered at a more leisurly pace to prevent errors committed in haste because of inadequate consideration and discussion.

RESOLUTION ON THE RANKING OF MEDICAL SCHOOLS

On behalf of the AAMC Council of Deans, the COD Administrative Board repudiates the concept, methodology and results of the ranking of medical schools conducted by the magazine Private Practice and reported in its March 1980 issue. The concept of identifying "the ten best and ten worst" of the nation's medical schools, all of which are accredited by the Liaison Committee on Medical Education, is both repugnant and mischievous. All provide quality education. Each is a complex institution with a variety of missions including different mixes of research, patient care, and community service. Any overall rating which fails to account for this complexity, and the diversity of objectives and the approaches used to accomplish them, is a gross distortion which does a disservice to the American public. Several fine institutions which are admirably serving locally and institutionally defined objectives are maligned by this exercise which, without standards or criteria, generates a ranking list which inevitably has a bottom irrespective of the high quality of the group as a whole.

Adopted by the Council of Deans
Administrative Board, March 20, 1980

COD BOARD RESOLUTION ON A COMMUNICATION
FROM THE AMA STUDENT BUSINESS SECTION

The chairperson of the AMA Student Business Section recently communicated with various officials of each U.S. medical school forwarding a "policy statement" adopted by the AMA House of Delegates "to clarify and protect the rights of medical students." To preclude the possibility that this action be misinterpreted, the Administrative Board of the Council of Deans adopted the following clarifying statement.

While it is confident that each medical school welcomes the advice of concerned individuals and organizations, particularly those with such longstanding interest in medical education as the AMA and its associated student group, the Council of Deans of the Association of American Medical Colleges states unequivocally for the record that academic policy and procedure are uniquely the province of each institution's internal governance process which is both responsible and accountable for its decisions. External evaluation of the adequacy of the academic program is accomplished through periodic review by the Liaison Committee on Medical Education; legal redress is available for violations of students' rights. The deans of U.S. medical schools do not recognize statements of "policy" of external organizations, which purport to govern matters of institutional responsibility, as binding on their institutions.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS
ANNUAL BUSINESS MEETING
Monday, November 5, 1979
2:00 pm - 5:00 pm
Monroe Room
Washington Hilton Hotel
Washington, D.C.

MINUTES

I. Call to Order

The meeting was called to order at 2:00 p.m. by Stuart Bondurant, M.D., Chairman.

II. Quorum Call

Dr. Bondurant announced the presence of a quorum.

III. Consideration of Minutes

The minutes of the April 25, 1979, Spring Business Meeting held at the Radisson Resort & Racquet Club in Scottsdale, Arizona, were approved as submitted.

IV. Chairman's Report

Dr. Bondurant welcomed the Distinguished Service Members present and invited them to participate fully in the discussions.

He noted the need to modify the agenda to accommodate to the schedule of the presenters who had competing commitments.

He summarized five actions taken by the AAMC since the previous meeting. First was the promulgation of the technical standards which the AAMC developed for the general guidance of member schools in their consideration of admissions standards vis-a-vis the admission of handicapped individuals. He noted that the Supreme Court had affirmed the ability of institutions to exercise appropriate judgments in this regard in its ruling in Southeastern Community College v. Davis, in which the AAMC participated as amicus curiae.

The second matter discussed the successful effort of the AAMC to acquaint HEW with the complexity of issues involved in its proposal that institutions conducting research be required by regulation to provide compensation to subjects injured in the conduct of research. The issue has been referred to the HEW Ethics Advisory Board for further study and recommendation.

He then described the AAMC participation as amicus curiae in the case of Forsham v. Califano which involved the accessibility, by way of a Freedom of Information Act request, of raw data acquired in the course of research conducted pursuant to a government grant. The issue involves the question of whether the data is the property of the government--an agency record--or of the institution conducting the research and thus shielded from the disclosure requirement of the FOIA. The AAMC brief supported this latter position.

The report of the AAMC Task Force on Graduate Medical Education had been distributed to all members of the Assembly and would be the subject for discussion of a special meeting of that body. Dr. Bondurant noted that the Executive Council had determined that the report required the addition of a preamble describing just what a resident is. He offered the opportunity for members of the Council to offer their own views of the report at this meeting.

The Spring Meeting of the COD had been scheduled for April 9-12 at Fort Lauderdale, Florida. The location was selected in deference to the preponderance of swimming pool sitters and tennis players among the membership. He invited the deans to bring their wives and asked that they plan to stay through the Saturday business meeting session.

Finally, Dr. Bondurant described the meeting held the previous evening with the officers of the Organization of Student Representatives. The students presented a total of seven resolutions which had been adopted by the OSR during the course of their meeting on Sunday. One concerned the uniform application for GME, a subject for discussion later in the meeting.

Dr. Stone asked whether the AAMC had taken any position on the Federation of State Medical Boards proposal that a new Flex I - Flex II licensure sequence be established. The answer was in the negative.

V. President's Report

Dr. Cooper thanked the Council for its participation and support over the past year in the development of policy and particularly in contacting their Congressmen on important issues. He noted that his address on the following day would cover a broader perspective but that his intention for today was to focus on legislative matters.

The first legislative issue dealt with standardized testing. The New York statute on this subject made it impossible for the AAMC to continue to offer the test in that state because of its requirement that test questions and answers be disclosed after each test. He described the test characteristics which made compliance impossible. Discussions with Senator LaValle, chief sponsor of the New York bill, could find no grounds for accepting what the AAMC had offered as alternative non-destructive means for achieving the statute's intended purposes. Dr. Cooper noted that the AAMC continued to explore all options to permit

it to continue to offer the test in New York, including the possibility of a suit against the state. Similar legislation had been offered in the U.S. Congress but a mark-up of the bill had been cancelled.

Dr. Cooper reported that H.R. 2222, defining residents as hospital employees for collective bargaining purposes, had been reported out of the House Committee on Education and Labor and had been referred to the Rules Committee which had not yet granted a rule. No action had been taken in the Senate.

Two attempts in the State of California of the PNHA to unionize residents were being fought by the AAMC, one at the Long Beach VA and the other at the University of California. AAMC is amicus on the side of the VA and the University, participating through our legal counsel from the firm of Fulbright & Jaworski. The PNHA challenge of the NLRB decision in the Cedars Sinai case had been the subject of a three judge panel of the Circuit Court of Appeals decision subsequently vacated by the full Court sitting en banc, which has agreed to rehear the case. The unfavorable decision thus may be overturned by the appeals court, but may ultimately be the subject of a Supreme Court decision.

The AMA has withdrawn from the Liaison Committee on Continuing Medical Education; remaining members met and determined to continue its accreditation function. The LCCME requested that AMA reconsider its action.

Dr. Cooper noted the continuing support of the Federation of State Medical Boards for the LCCME and the statement of its Executive Director, Harold Jervey, the previous summer that if the LCCME did not exist, the FMSB would set about to create it because of FSMB dissatisfaction with the handling of accreditation by the AMA.

Section 227 draft regulations have been reviewed by the Association's Task Force. While there have been extensive negotiations with the staff of HICFA, the proposal continues to contain the fiscal test which would have disastrous consequences for many of our institutions. The Executive Committee of the AAMC had a meeting scheduled with HEW Secretary Harris and this issue was to be discussed with her. Representative Satterfield had proposed a repeal of Section 227, and at a hearing on the subject, AAMC witnesses were impressed with the responsiveness of members of the committee to descriptions of the problems that this provision would create. Dr. Cooper cautioned, however, that a simple repeal of Section 227 would not necessarily resolve all of our problems because other statutory provisions grant HEW sufficient authority to undertake much of what it was doing under Section 227. Thus, at a minimum, there is a need for strong language in the report on the bill which would be directive to HEW on the method of calculating allowable fees.

Section 223 classification of teaching hospitals continues to be of substantial concern and the AAMC staff has undertaken a comprehensive study of better ways to identify and characterize the unique features of the teaching hospital.

The Sloan Commission Study on the relationship between higher education and the government appears to continue to perpetuate distorted views of medical education and will likely contain recommendations detrimental to medical education.

VII. Discussion Items

A. Report of the Ad Hoc Committee on Clinical Research Training

Dr. Thier, chairman of the committee, appeared to describe the facts which define the problem, to relate the explanations which have been advanced, and to communicate the suggestions of the committee for appropriate courses of action.

The percentage of M.D.'s receiving first grants as compared with the total of grants awarded has dropped approximately 50% in a five year period to 1977. While the number of M.D.'s on faculties has increased substantially, the percentage of M.D.'s on faculties receiving awards has also dropped by about 50%. Those who applied for grants received them with the same success rate as in the past, therefore it appears that there has been no increase in applicants comparable to the increase in the number of faculty. An AAMC survey indicates that interest in pursuing research careers has dropped off by about 50% during the same period. The number of full time faculty positions unfilled has recently been increasing and has reached its highest point at the present.

The OSR has expressed its concern that insufficient research opportunities are available. This appears to be confirmed by an AAMC survey.

The number of people entering research careers is very close to the lowest range of estimates of need.

A number of recommendations for actions which could be taken by the AAMC, medical schools, the Federal government, and the private sector as described in the report were discussed briefly.

During the discussion it was pointed out that foundations and the government have strengthened the movement toward primary care, apparently to an excessive degree, and should have a role in rectifying the situation.

B. S. 988 - Health Science Promotion Act of 1979

Dr. Kennedy reported on the legislative status of the bill and changes made in four revisions of the bill, the final since the staff analysis which appeared in the agenda book.

Dr. Theodore Cooper followed giving his assessment of the bill. He stated his own agreement with the staff analysis and positions taken, in all except one respect. He did not concur with the statement that the Congress did not have access to good scientific advice. Consequently, he was critical of the staff counter proposal. He did not believe that such a council could give good advice, engage in a constructive dialogue with agency heads; it would, however, be a drain on limited resources.

Dr. Ross stated his belief that the bill has many things upside down and backwards. He was, however, persuaded that a modification directed toward providing informed information to Congress might be helpful. On balance, Dr. Cooper might be right, but, as he said, sometimes a compromise is a useful legislative device. He noted the split vote of the AAMC's biomedical research committees on this issue.

Dr. Ross concurred in the judgment that a special provision for funding innovative and unconventional projects was a bad idea-- that is what study sections and advisory councils seek to do, with the judgment that the proper place for lay input is at the Council level, and with the conclusion that an appeals process is unnecessary.

The discussion which followed elicited the opinion that the bill had momentum in the Senate and was likely to be passed but that no action was anticipated in the House in the near future. Part of the problem is that legislators have heard no outcry from the scientific community. The paperwork reduction provisions and the authorization of the Director of NIH to appoint study sections and consultants have persuaded some, including university presidents and FASEB, to support the bill.

Dr. Bondurant summarized the discussion by stating that the bill is substantially flawed and that the AAMC should oppose it, while at the same time, attempting to address some of the problems which need attention in alternative ways.

C. Ad Hoc Committee on Continuing Medical Education

Dr. Mayer, chairman of the committee, reviewed the report which was contained in the agenda book. The report had been considered on two occasions and endorsed by the Executive Council.

The response of the Council to the report was quite positive and Dr. Mayer and his committee were thanked for their work.

D. A Position Paper: The Expansion and Improvement of Health Insurance in the United States

Dr. Gronvall, chairman of the AAMC's ad hoc committee on National Health Insurance, reviewed the draft position paper contained in the agenda, the considerations which led to its development, and the actions taken by the AAMC Executive Council in response to the report.

The committee recommended that the Association's policy be directed at "the need for expansion of health insurance in the United States" and identified three major disparities that persist in the current system: 1) the lack of or inadequacy of basic health insurance coverage of low income Americans; 2) the inadequacy of health insurance protection against the high cost of catastrophic illness; and 3) the lack of a generally accepted minimum standard for basic health benefit plans. The recommendations of the committee were directed at approaches to remedy these deficiencies.

The Executive Council responded to the recommendations by rescinding the AAMC's previous position which was substantially more comprehensive in character and expressed general approval of the approach taken in the draft. But, having several specific concerns with several items in the report, returned the document to committee and staff for further revision in response to its criticisms. The draft in the agenda book reflected the original language as well as the proposed revisions, together with several alternative formulations on specific matters.

Members of the Council offered essentially four categories of comments on the draft:

First, there was a series of comments which argued the appropriateness of a mandated, as opposed to an incentive oriented, catastrophic health insurance program funded by employers. Several thought this was an intrusion into labor management relations, while others believed that a mandated program was essential.

Second, several deans questioned the advisability of the Association recommending a program of catastrophic health insurance at all. Their argument in opposition related to the fact that this type of health insurance had little actual impact on health status, was highly inflationary in a period of cost containment, and might appear self-serving to the Association's members who are major providers of high-cost sophisticated services and technology.

Third, one dean suggested that the Association ought not take a position regarding the scope of coverage of any health insurance program, and should instead limit its concerns to support of adequate funding for medical education and research under any chosen national health insurance program.

Finally, another dean criticized the document as being overly focused on financial matters and suggested that, while these need to be addressed, the tone of the document should be more altruistic, focusing more on the general public welfare.

The comments were to be forwarded to the Executive Council for further deliberation on the proposed position.

E. Task Force on Support of Medical Education

Dr. Edward Stemmler, chairman of the Task Force, reported that it had reached no final conclusion on the nature of the proposals for health manpower legislation which the AAMC should support. It had adopted general principles which had been reviewed by the Council the previous November and these appeared to retain their validity. More specific positions would await the maturation of the legislative process and the actual appearance of bills with specific provisions which the AAMC could examine.

Dr. Stemmler, on behalf of the Task Force as well as many deans and AAMC staff, continues to maintain close communication with the staffs of the relevant Congressional committees as well as with appropriate executive branch officials. These contacts appear to be fruitful in that they offer an opportunity to educate these individuals on the needs of medical education. The federal officials, to date, exhibit a sincere interest in learning and continuing the dialogue although they continue their pessimism on the prospect for unfettered institutional support.

F. Uniform Application for Graduate Medical Education Programs

D. Kay Clawson, who served as a member of the AAMC Task Force on Graduate Medical Education, noted the availability of a draft of the proposed Uniform Application form. He pointed out that its development was one of the recommendations of the Task Force which was already being carried out. He solicited the deans' review and criticism of the form as one means of assuring its utility. He also reported that the OSR had expressed an interest in calling the deans attention to a model questionnaire on graduate training evaluation which the OSR had developed. The purpose of the questionnaire was to assist schools who were interested in collecting the views of recent graduates as a means of better informing students in their quest for graduate positions.

VI. Consideration of Assembly Action Items

A. Election of Provisional Institutional Member

The Council of Deans on motion, seconded and carried, recommended the election of Oral Roberts University School of Medicine to Provisional Institutional Membership by the AAMC Assembly.

B. Election of Distinguished Service Members

The Council of Deans on motion, seconded and carried, recommended that the AAMC Assembly elect the following persons to Distinguished Service Membership:

Edward N. Brandt, Jr.
Christopher C. Fordham III
William J. Grove
Marion Mann
Clayton Rich

C. Election of Officers

On recommendation of its nominating committee and on motion, seconded and carried, the Council of Deans elected Steven C. Beering, M.D., Dean and Medical Center Director, Indiana University School of Medicine, as its Chairman-Elect, and Richard H. Moy, M.D., Dean and Provost, Southern Illinois University, as Member-at-Large of the Council of Deans Administrative Board.

In a subsequent action, the Council endorsed the recommendation of its nominating committee that the Assembly elect:

Chairman-Elect of the Assembly--Julius R. Krevans,
Dean, University of California-San Francisco

Council of Deans Representatives to the Executive
Council--Theodore Cooper, M.D., Ph.D., Dean, Cornell
University Medical College, and Leonard M. Napolitano,
Ph.D., Dean, University of New Mexico School of Medicine

VIII. Adjournment

There being neither outstanding old business nor new business needing to be brought before the Council, Dr. Bondurant adjourned the meeting at 4:00 pm. This meeting was followed by a program session consisting of a report by Dr. Albert P. Williams, Senior Economist of the Rand Corporation. Dr. Williams' paper traced the progressive diffusion of board certified specialists into non-urban areas.

Revised as of
2/4/80

A POSITION PAPER: THE EXPANSION
AND IMPROVEMENT OF HEALTH INSURANCE
IN THE UNITED STATES

The Association
of
American Medical Colleges

August, 1979

Introduction

Due to renewed and intensified Congressional interest in national health insurance, particularly catastrophic coverage and a phased approach toward a comprehensive program, the Association of American Medical Colleges (AAMC) appointed a National Health Insurance Review Committee in August 1979. The Committee was charged to review, and recommend appropriate revisions in, the Association's November 1975 policy statement on national health insurance. The members of the Committee were Chairman John A. Gronvall, M.D., Dean of the University of Michigan Medical School; John W. Colloton, Director and Assistant to the President for Health Services at the University of Iowa Hospital & Clinics; James F. Kelly, Ph.D., formerly Executive Vice Chancellor of the State University of New York-Albany now retired; William H. Luginbuhl, M.D., Dean of the Division of Health Sciences at the University of Vermont College of Medicine; Peter Shields, M.D., Chairman of the AAMC's Organization of Student Representatives; Virginia V. Weldon, M.D., Professor of Pediatrics and Assistant to the Vice Chancellor at the Washington University School of Medicine; and Charles B. Womer, President of the University Hospitals of Cleveland.

Summary Findings and Recommendations

As a first order of business, the Committee carefully reviewed the pervasiveness and comprehensiveness of the health and hospital insurance coverage presently in force for American citizens. The members were surprised and pleased by the estimates that as high as 94 percent of all U.S. residents have basic coverage in one form or another¹ and that quite comprehensive coverage is now in force for much of the nation's population as well.

Hospital and health insurance is provided as a fringe benefit by a wide variety of public and private sector employers and has become increasingly pervasive during the last decade, accountable, at least in part: to the favorable tax treatment of this type of benefit, either as income to the employee or a cost to the employer; to the enterprise of the private insurance industry; and to important public programs such as Medicare and Medicaid.

However, the Committee also identified three major disparities: (1) the total absence or incompleteness of basic health insurance coverage for many low income Americans; (2) the lack of adequate health insurance protection for many against the high cost of catastrophic illness; and (3) the want of consensus on a minimum standard for basic health benefit plans.

The Committee concluded that the Association's policy should be directed at "the need for expansion and improvement of health insurance in the United States" and, to obviate these deficiencies, recommended a number of remedial actions which would, among other things, expand entitlements under existing governmental programs, as well as the scope of health benefits provided in the private sector. Clearly, the financial implications of such proposals are considerable, particularly in the current cost containment environment. The Committee fully recognized that its recommendations amount to little more than grand promises if an adequate financial base is not established to underwrite them. Therefore, if there is to be a genuine national commitment to extending health insurance coverage to those most in need, there is inherent in the recommendations which follow an assumption of willingness on the part of governments, industry and other payers of health care to provide the financial support essential to the success of the effort.

The specific recommendations of the AAMC National Health Insurance Review Committee were:

- (1) The Medicaid program should be expanded and improved through the provision of federal incentives to the states to foster broader eligibility of low-income people for Medicaid coverage and to standardize the scope of basic benefits offered. Such standardization would require an expansion in benefits in many states. In addition, these modifications should recognize and adjust for regional differences in characteristics such as income levels.
- (2) A program should be developed which would provide incentives for employers to make catastrophic health insurance coverage more widely available. Employers would be given a specified amount of time (e.g., five years) within which to purchase such coverage for their employees, after which stricter requirements would be mandated. In addition, insurance companies should be requested to participate, as a social responsibility, in state or regional insurance "pools" that would sell approved catastrophic insurance plans to the non-employed, the self-employed, part-time workers, high risk individuals, "Medicare beneficiaries," and others not covered by employers. Though these individuals would not be required to buy the catastrophic coverage, they or a government sponsor would at least be guaranteed an opportunity to buy it from the industry pools.
- (3) An independent certifying body or commission, composed of representatives of insurance carriers, providers and consumers, should be created to establish a minimum standard basic health insurance benefits package. This Commission would review all basic health plans and provide its "seal of approval" only to those meeting the minimally acceptable standard. The Committee believed that the approval of health insurance policies by a voluntary body would provide a powerful incentive to insurers

to offer at least minimally acceptable basic benefits packages and to employers to upgrade inadequate employee basic health plans. Furthermore, it would serve as a source of authoritative information for the protection of the consumer public.

In addition to the above proposals, the Committee concluded that the Association should make recommendations of broad applicability on: (1) the appropriate use of cost-sharing mechanisms in the financing of the nation's health insurance systems; (2) the fair and reasonable reimbursement of physicians and institutional providers of services; (3) the propriety of financing graduate medical education through the patient service revenues of hospitals; and (4) the encouragement of philanthropic contributions to the health care system.

Expanded Eligibility and Standardizing of Benefits Under Medicaid

Since the advent of the Medicaid program in 1965, great strides have been made to expand the financial access of the poor to health care services. In fiscal year 1979, recipients of medical services under Medicaid numbered an estimated 21.4 million, an increase of more than 77 percent from the FY 1969 level of only 12.1 million.² Despite the success in making medical services more accessible to low income individuals, an estimated 11 to 18 million Americans (approximately five to eight percent of the total population, most of whom may be categorized as "poor" or "near-poor") still lacked any coverage for basic health services in 1978. An estimated 19 million Americans, most of whom may be categorized as "working poor" (those from families with incomes of less than \$10,000 holding only individual private policies) had health insurance coverage that failed to provide adequate basic benefits for hospital and physician services.^{3, 4} This population of either totally unprotected or

or inadequately covered low-income working Americans comprises the so-called "coverage gap"--citizens unable to either afford private coverage for basic health benefits or qualify for such basic protection under public assistance programs, in particular Medicaid.

Medicaid was designed to assist specified categorical groups of low-income people: the low-income aged, blind, and disabled; recipients of cash assistance under the Supplemental Security Income (SSI) program; and families receiving payments under the Aid to Families with Dependent Children (AFDC) program. Currently 35 states provide coverage not only to cash assistance, but to all SSI recipients. The states also have the option of including the medically needy--persons whose incomes are too high to be eligible for cash assistance but not sufficient to pay for needed medical care. The states must define the income limits for the medically needy within certain guidelines; thirty-three now finance medical services for the medically needy, with definitions of income limits for eligibility varying considerably. In 1975, variations of these kinds contributed to the exclusion from basic coverage under Medicaid of an estimated 8 to 10 million persons with incomes below the poverty level.^{5, 6}

While the AAMC applauds the Medicaid program for the significant gains already achieved in insuring those with low-incomes, it is convinced that a targeted approach is needed to focus basic coverage in the current area of greatest need, the "gap" population. Such an approach would retain the pluralistic structure of current third party coverage, with Medicare for the aged and disabled, private health insurance for the working population and their families, and Medicaid for the low-income and medically indigent. In addition, however, the Medicaid program would be augmented by the establishment of federal

incentives to the states for (1) the extension in many states of eligibility for Medicaid to previously unqualified low-income individuals and (2) standardizing the scope of basic benefits under the program in a manner that would adequately recognize regional differences in such attributes such as income levels.

The federal government should assume responsibility for determining the specific nature of the proposed incentives (financial or otherwise) to be offered to the states. However, states could take a number of actions (individually or in combination) to close the "gaps" in coverage under Medicaid:

- all categorical requirements could be abolished, thus basing eligibility solely on financial criteria (e.g., income below specified levels);
- the varying state income level specifications for eligibility of the medically needy could be eliminated, as well as the current linkage to eligibility under welfare programs that generally excludes single individuals and childless couples under age 65;
- Medicaid coverage could be extended to unemployed fathers in those 24 states that do not currently cover them; and
- the Medicaid spend-down (i.e., when medical expenses incurred are equal to the difference between the individuals's income and the protected standard) program could be extended to every state, and eligibility requirements could be standardized to eliminate existing uncertainties about program requirements.

States participating in Medicaid are required to include the following medical services: inpatient, outpatient and rural health clinic, laboratory and x-ray, skilled nursing and home health for those 21 years or age and over, physician, family planning, and EPSDT (Early and Periodic Screening, Diagnosis,

and Treatment) for those under 21 years of age. Beyond these, the states may include a number of other services, such as drugs, eyeglasses, and dental services, for which federal matching funds are available. They also have the discretion of deciding the amount or level of each service included in their programs (i.e., one state may decide to cover 30 inpatient hospital days per Medicaid eligible person while another may cover 90 days) and may also impose other restrictions, such as cost-sharing requirements. Availability of a range of options such as these has led to substantial variations among the states in their expenditures for medical services for qualified individuals, as well as in the scope and duration of basic and optional benefits offered to this population.

As states continue to face fiscal pressures, "more creative" ways of extending limits on the amount, scope and duration of services can be expected. To ensure that Medicaid recipients nationally receive at least an adequate basic package of benefits, the incentives that the AAMC proposes the federal government establish should encourage states to standardize their Medicaid coverage on the basis of a uniform set of basic benefits. Where fiscal constraints force a state to reduce its Medicaid expenditures, the potential health effects should determine the specific services selected for modification; limitation, rather than elimination of covered services should be encouraged.

Employer-Based Plans and Voluntary Insurance Industry Pools for Catastrophic Health Insurance Protection

"Catastrophic" health care costs are broadly defined as large unpredictable medical expenses usually associated with a major or chronic illness, serious injury, or terminal disease. While the vast majority of Americans are protected against the costs of normal episodes of illness, a very expensive unusual,

unexpected or terminal illness or accident can cause financial ruin. Consumers presently have three primary sources of assistance in meeting the costs of catastrophic health care: (1) private insurance, (2) public programs, and (3) tax subsidies. Collectively, these sources serve to reduce significantly the portion of Medical expenses paid directly by the consumer and thereby decrease the incidence of catastrophic costs to the consumer. However, problems do remain in this current system of coverage.

In fiscal year 1978, an estimated 37 million Americans lacked protection against catastrophic expenses. This group was composed of 18 million uninsured who were ineligible for assistance from non-insurance sources (e.g., Medicaid, Workmen's Compensation, and the Veterans Administration), and 19 million persons with family incomes of less than \$10,000 holding only individual (non-group) private insurance policies with inferior coverage. The remainder of the population was reported to have had some protection against catastrophic expenses, however the adequacy of that protection varied substantially depending on the source of coverage.

Growing public concern about the high cost of catastrophic care has become manifest in recent years through such phenomena as: a rise in private health insurance plans with high coverage limits; the adoption of public catastrophic insurance programs in five states; and the introduction of numerous pieces of legislation in Congress proposing catastrophic coverage nationally. In the face of an emerging consensus that the nation may be ill-advised to enact, and unable to afford or administer, an entirely new system of universal comprehensive national health insurance and that catastrophic illnesses can lead rapidly to personal insolvency, the AAMC advocates the development of a nationwide catastrophic health insurance program as the second component of a targeted approach to expansion and improvement of health insurance in the United States.

More specifically, the Association supports a catastrophic health insurance program which would provide incentives to employers to make catastrophic health insurance coverage more widely available. Employers would be given a specified amount of time (e.g., five years) within which to purchase such coverage for their employees, after which stricter requirements would be mandated. Furthermore, private insurance carriers would be requested to participate as a social responsibility, in state or regional insurance "pools." These pools would sell approved basic catastrophic insurance plans to the non-employed, self-employed, part-time workers, high-risk individuals, "Medicare beneficiaries," and others not covered by employers. Though these individuals would not be required to buy catastrophic coverage, they or a government sponsor would at least be guaranteed an opportunity to buy such coverage from the industry pools. It should be recognized that the primary objective of catastrophic health insurance coverage is to protect individuals from becoming financially insolvent rather than to improve the health status of its population, even though the latter might occur as a secondary and highly desirable benefit. Certainly, it would be expected that the proposed program would enhance the quality of the lives of many individuals, particularly of those afflicted and their families.

Services not traditionally included in an individual's personal health care expenditures but financed instead usually through general revenues as public health care expenditures (e.g., long-term care for chronic mental illness) should be excluded from coverage under the catastrophic health insurance program. The federal component of the Medicaid program, which now finances long-term custodial care in nursing homes in many states, should provide an appropriate financial incentive to the states to accept, as a responsibility of their Medicaid plans, the provision of long-term care for individuals who

cannot pay for it as a personal health care expenditure. The amount spent on such care should be reasonably balanced with expenditures for acute care services.

The Association recognizes that long-term care, often not addressed in the debate on catastrophic coverage, is perhaps the most significant catastrophic expense problem. From 1966 to 1975, nursing home expenditures rose more than 500 percent. Provisional data from the 1977 National Nursing Home Survey conducted by the National Center for Health Statistics demonstrate how nursing home costs add up to catastrophic proportions. The average cost per resident day at nursing homes was \$24.04 or \$8,774 per annum.⁸ An estimated 1.3 million Americans were residents of nursing homes in fiscal year 1978 for six months or longer, at an aggregate cost of approximately \$14.7 billion. Almost 55 percent of that cost, or \$8 billion, was estimated as the amount directly paid by consumers, most of whom had modest incomes.⁹ While the Association cannot offer a permanent solution for this problem, it does encourage the debate on catastrophic coverage to continue and eventually address the long-term care issue explicitly.

Certification of Minimally Acceptable Basic Health Benefits Plan by a Voluntary Independent Body

This position paper has already documented data describing the disparities existing in the coverage of Americans for basic health services. There are 18 million individuals and families without any such protection at all. Moreover, the evidence is clear that even among existing basic health benefits packages there is tremendous variance in scope, amount and duration of benefits, with no certainty of at least minimal acceptability or coverage. To address this issue, the AAMC recommends that an independent certifying body or commission, composed of representatives of insurance carriers, providers, and

consumers, be created to: (1) establish a minimum desirable standard for a basic health insurance benefits package and review all basic health plans and provide its "seal of approval" only to those meeting the minimally acceptable standard. In identifying a desirable basic benefits package, the commission should include, at a minimum, coverage of inpatient care, physicians' services, ambulatory care, diagnostic laboratory and x-ray services, short-term mental health services, and home health care. The AAMC believes that this certification of health insurance policies by a voluntary body would provide a powerful incentive to insurers to offer at least minimally acceptable basic benefits packages and to employers to upgrade deficient employee basic health benefits plans. Furthermore, it would serve as a source of authoritative information for use in protection of the public interest.

Patient Coinsurance and Deductibles

The targeted approach recommended by the Committee for the expansion of health insurance in the U.S. is designed to provide ready financial access to the health care system in the areas believed to be of greatest need, and to shift the financial burden of health care from personal expenditures to insurance coverage and public assistance. Cost-sharing mechanisms such as deductibles, coinsurance, or copayments, when included in health insurance proposals, should be held to appropriate levels, and their effect on utilization carefully evaluated. They should: only be high enough to avoid over-utilization; not be burdensome in the aggregate to a family; be waived for low-income persons; not be applicable to essential minimum and preventive services and their administrative costs should not exceed the savings from avoided over-utilization.

Provider Reimbursement Standards

Integral to the targeted expansion of the health insurance system is the

establishment of a reimbursement policy which provides fair and reasonable payments for services. A necessary pre-condition is the existence of a sufficient financial base to underwrite the commitments. The policy for physicians' services should provide payment for high quality professional medical services on an equal basis irrespective of the setting in which the services are provided. Such a reimbursement policy should not impede the training and education of medical students and residents, and should recognize the team approach to professional care in the teaching setting. The policy should not, for example, in setting conditions under which fee-for-service reimbursement of teaching physicians is to be made, require the kind of financial test and other conditions imposed by Section 227 of the Social Security Amendments of 1972.

A fair and reasonable reimbursement policy also should meet the legitimate financial needs of the institutional providers of the services, including the replenishment of capital for the maintenance of an up-to-date facility. Allowable expenses for reimbursement should include the depreciation of capital assets, the amortization of debt, and the accumulation of an adequate operating margin. Furthermore, the reimbursement policy should reflect the fact that there are valid differentials among providers in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis of patients in the teaching hospital; (2) the comprehensiveness and/or intensity of services provided by the teaching hospital; and (3) the teaching hospital's commitment to the incremental cost of providing the environment for medical and paramedical educational programs.

Manpower Development and Distribution

The AAMC is strongly of the view that an expanded and improved health insurance system in this nation would provide an appropriate mechanism for financing graduate medical education as a means of replenishing the health manpower pool. Graduate medical training includes important elements related to education and delivery of health services as integral parts of the training, and is thus appropriately financed by the health delivery system. Expansion of opportunities for graduate medical education in specialties deemed in short supply should continue to be encouraged through financial incentive programs. Financing policies should: (1) provide sufficient support to meet the cost of program development and maintenance, (2) not place an undue burden upon institutions to cover marginal costs, and (3) not be so restrictive as to inhibit desirable innovations in graduate medical education.

Philanthropy

Philanthropic contributions have provided non-profit and public hospitals with critically needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new innovative programs. This vital support has, inter alia, stimulated research and development in medical care organization.

Any approach to the expansion and improvement of health insurance in this country should recognize and encourage the contribution of philanthropy to institutions within the health care system. More specifically, the tax system should continue to provide deductions from corporate and individual income taxes for charitable contributions. Hospital reimbursement formulas should specifically provide that unrestricted endowment principle and income, donations, legacies, bequests and other charitable contributions not be included

in formulas establishing payment rates. Finally, expenditures of funds derived from philanthropy should be under the control of the governing board of the respective hospital.

Conclusion

It is the firm belief of the Association of American Medical Colleges that adoption of the three major recommendations and four operating principles set forth in this document would result in an effective and cost efficient targeted approach to the expansion and improvement of health insurance in this nation. Furthermore, the AAMC contends that use of this approach will enable achievement of greater access to coverage by those most in need.

NOTES

1. Sudovar, S. G. and Sullivan K., National Health Insurance Issues: The Unprotected Population, Roche Laboratories, 1977, p. 2.
2. Medicaid/Medicare Management Institute, Data On the Medicaid Program: Eligibility, Services, and Expenditures - 1979 Edition, DHEW, Health Care Financing Administration, p. 31.
3. U.S. Congressional Budget Office, Profile of Health Coverage: The Haves and Have-Nots, March 1979, p. 13.
4. U.S. Congressional Budget Office, Catastrophic Health Insurance, January 1977, p. 17.
5. Medicaid/Medicare Management Institute, op.cit., p. 24.
6. U.S. Congressional Budget Office, Catastrophic Health Insurance, op. cit., p. 26.
7. Ibid., p. 15.
8. Office of the Assistant Secretary for Health, Health-United States: 1978, DHEW, Public Health Service, December 1978, p. 96.
9. U.S. Congressional Budget Office, Catastrophic Health Insurance, op. cit., p. xiv.

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THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION,
ITS DEVELOPMENT AND CURRENT STATUS

(March 1, 1980)

The Genesis

The Liaison Committee on Graduate Medical Education was established in 1972 by an agreement negotiated among the AAMC, AMA, ABMS, CMSS, and AHA. Its current composition is:

AAMC	-	4	representatives
AMA	-	4	"
ABMS	-	4	"
AHA	-	2	"
CMSS	-	2	"
Federal Government	-	1	"
Public Member	-	1	"
Resident (appointed by AMA-RPS)	-	1	"

In addition, representatives from the Association of Hospital Medical Educators, the National Residency Matching Program, and the Educational Council for Foreign Medical Graduates are participant observers.

Shortly after the sponsoring organizations reached consensus on five points of agreement, a proposal for the establishment of the LCGME was presented and ratified by the sponsors. The five points of agreement were:

1. As soon as possible, there will be established a Liaison Committee on Graduate Medical Education, with representation from each of the five organizations, to serve as the official accrediting body for graduate medical education.
2. Simultaneously, there will be established a Coordinating Council on Medical Education composed of representatives from each of the five organizations to consider policy matters for both undergraduate and graduate medical education for referral to the parent organizations.
3. The existing Liaison Committee on Medical Education and the new Liaison Committee on Graduate Medical Education will have the authority to make decisions on accreditation in their respective areas within the limits of policies established by the parent organizations and with the understanding that Residency Review Committees will continue to function.
4. All policy decisions will continue to be subject to approval by the parent organizations.

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5. Policy recommendations may originate from any of the parent organizations or from the two liaison committees, but will be subject to review by the Coordinating Council before final action is taken by the parent organizations.

The key clauses in the proposal to establish the LCGME were:

Authority

The Liaison Committee on Graduate Medical Education shall operate on the basis of authority delegated by the parent professional organizations.

Purpose

- A. To consolidate existing multiple accrediting activities in graduate medical education under a single accrediting agency qualified for recognition by the U.S. Commissioner of Education.
- B. To establish a body for supervision and accreditation of graduate medical education comparable to that existing for undergraduate medical education.

Function

- A. To accredit programs of graduate medical education recommended for approval by residency review committees.
- B. To coordinate the development of improved review and evaluation procedures of residency review committees.
- C. To establish more effective central administrative procedures for the conduct of accreditation in graduate medical education.
- D. To develop and propose to the Coordinating Council on Medical Education policies and methods whereby graduate education programs in the various specialties may be related more closely to each other and to the total educational enterprises in their individual institutions.
- E. To recommend studies directed toward improvement in the standards for organization and conduct of programs in graduate medical education.

Officers

There shall be a Chairman and a Vice Chairman, who shall be from different professional organizations. The officers shall be named in rotation by their respective professional parent organizations. The term of office shall be one year.

Financing

- A. The costs of accreditation in graduate medical education are currently borne primarily by the American Medical Association, with substantial additional support by the specialty boards and certain specialty societies. These same costs shall continue to be shared by those organizations for the time being, but the newly constituted Coordinating Council on Medical Education shall undertake, as one of its initial tasks, a study of costs of accreditation of graduate medical education and shall make recommendations concerning their allocation in the future.
- B. The expenses of the representatives of the various professional organizations shall be borne by those organizations. The expenses of the public representative shall be shared equally by all of the professional organizations. The expenses of the government representative shall be borne by the government.
- C. For the time being, the AMA shall continue to provide staffing and secretarial services for the residency review committees and in addition shall supply such services for the LCGME.

In 1973, the Coordinating Council on Medical Education adopted the following financing proposal and forwarded it to its sponsors for ratification.

At its meeting on September 10, 1973, the Coordinating Council on Medical Education voted to adopt the following recommendation of its Task Force on Financing the Accreditation of Graduate Medical Education and to forward it to the five parent organizations for approval:

"In meeting the costs of accreditation of graduate medical education, the American Medical Association would agree to pay one-half of the total cost. The remaining one-half would partly be defrayed by an annual accreditation fee charged to institutions offering residency programs of \$100 per program, and the remainder would be divided equally per seat among the five parent organizations who have members seated on the Liaison Committee on Graduate Medical Education; i.e., American Board of Medical Specialties, American Hospital Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies."

The Coordinating Council regards this as a temporary solution to the problem of dealing with the costs of accreditation of graduate medical education, particularly in view of the fact that the entire process of survey and accreditation in the field of graduate medical education is being studied by the

Liaison Committee on Graduate Medical Education. The CCME action is regarded as an interim action for a period of three years, subject to review within that period of time. If the parent organizations approve the proposal, implementation is planned to begin July 1, 1974.

The LCGME has operated under these agreements and financing plan to date. The only modification is that programs are charged a \$650 fee for periodic survey and evaluation rather than an annual charge of \$100. It officially began accrediting programs in graduate medical education in 1975 after its by-laws were ratified by its sponsors. The original purpose to seek recognition by the U.S. Office of Education was not pursued.

The Experience

From the outset, the Liaison Committee on Graduate Medical Education had difficulty in accomplishing the five functions it was mandated to undertake. These difficulties derived from several problems.

1. The residency review committees were accustomed to functioning independently and they resisted attempts by the LCGME to impose uniform procedures and policies on their activities.

This resistance has lessened with greater participation by RRC chairmen in the LCGME. Chairmen of the RRCs are invited to attend the LCGME meeting when their committees' actions are being reviewed. In addition, each September all RRC chairmen are invited to an LCGME meeting where they hold a one-half day session independently and also meet with the Committee.

2. The AMA staff which is responsible for serving both RRCs and the LCGME was resistant to change, was slow to implement LCGME actions, and at times appeared to misrepresent LCGME actions to the residency review committees. The original staff has now been completely replaced. The new staff is more responsive to the LCGME, but it appears to be hindered by AMA hiring and resource allocation policies.
3. The development of an annual budget for the LCGME and residency review committees has been hindered by AMA accounting and budgeting procedures. The LCGME's Subcommittee on Finance has not been able to develop a budget based upon identified program and staffing needs. Its main function has been to review and try to interpret a budget prepared by staff and approved by the AMA Board of Trustees.

4. Most of the significant policy changes recommended by LCGME have had to be reviewed and approved by the Coordinating Council on Medical Education and ratified by its sponsors. This has caused long delays in implementation of new policies.

As a consequence of these problems, important LCGME program modifications are as yet not implemented. Some of these are:

1. Revision of the General Requirements Section of the Essentials of Accredited Residencies.
2. The development of policies and procedures to accredit subspecialty training programs.
3. The development of new pre-survey data forms to collect in a common format institutional data needed by all residency review committees.
4. The development of institutionally based transitional first graduate year programs to replace the unsatisfactory flexible first graduate year programs.

Frustration with the impediments to LCGME's ability to carry out its functions caused the AAMC, ABMS, and CMSS to call for independent financing and staffing of the LCGME and RRCs. In response, in 1978 the Coordinating Council on Medical Education appointed a "parental commission" to study the problems and review proposals submitted by the sponsors. Proposals were submitted by AAMC, ABMS, and CMSS for an independent staff. The American Hospital Association proposed that a contract for staff services be negotiated with one of the sponsors - implicitly the AMA. This approach was accepted by the commission and the CCME. Attempts to draft a contract have been impaired by three factors:

1. The LCGME is not an independent legal entity with contractual authority.
2. The LCGME has no financial resources with which to negotiate.
3. The LCGME has been attempting to implement recommendations made by a subcommittee which reviewed the accreditation process. Their implementation will have financial implications, but a plan has not been developed by the AMA staff. Therefore, it is difficult to specify the contractual obligations which will be required in the future.

A Reaction

The American College of Surgeons (ACS) is one of the sponsors of seven

residency review committees. It has been the residency review committee sponsor which is most critical of the LCGME and of the staff services provided to the surgical residency review committees. The letters on pages 49 to 60 detail the concerns of the ACS. The letters focus on four major complaints.

1. The LCGME should not review the actions for approval or disapproval made by the surgical RRCs. The RRCs should have final accrediting authority and the LCGME should only serve as an appeals body.

Comment:

In practice the review of RRC actions by LCGME is not to judge the merits of the RRCs action, but to determine whether the reasons for the action are well documented and consistent with published special requirements. The LCGME does not change RRC actions, but does refer back to an RRC those which are not well documented or consistent with the requirements.

The LCGME has established an appeals mechanism, the first step of which is referral of the decision back to the RRC for reconsideration.

2. The General and Special Requirements should be reviewed and approved by all RRCs and not be subject to approval by the LCGME.

Comment:

The LCGME by-laws make it responsible for developing the General Requirements. They must be approved by the CCME and ratified by its five sponsors. A period of ten months was provided for RRCs and their sponsors to comment on the proposed revision currently being considered. The RRCs are responsible for developing the special requirements for training programs in their specialty. They must be ratified by each RRC sponsor. In every case this requires ratification by a specialty board and by the Council on Medical Education of the AMA. In 14 cases a specialty college also must ratify. After this lengthy process is completed the LCGME must also ratify the special requirements. The LCGME also requires that a statement of justification and impact accompany the changes in the special requirements.

In practice, LCGME ratification has caused little delay or controversy. Until 1978 the AMA House of Delegates had to ratify all changes in the special requirements. Now the Council of Medical Education can ratify them

but there is a requirement that the Council hold a "public meeting" before AMA ratification becomes final. It is too early to tell whether this change will shorten the delays imposed by the previous AMA procedures.

3. The "Structure and Functions of Residency Review Committees", a document prepared by the LCGME, should be subject to approval by all RRC sponsors.

Comment:

This document sets out the policies and procedures which are common to all RRCs. It was initiated by LCGME to attain some degree of consistency in RRC policies and procedures. It is subject to input from RRCs and their sponsors and is modified and updated annually. Approval by all RRC sponsors would require action by 32 independent organizations.

4. The staffing of both RRCs and the LCGME has been insufficient. A staff independent of any other organization should be established and the LCGME and RRCs should be financed independently of the sponsoring organization through charges to institutions and programs.

Comment:

This position is consistent with that of the AAMC, ABMS, and CMSS.

Following the exchange of letters which was initiated in 1977, the ACS, in late 1979, appointed an ad hoc commission chaired by G. Thomas Shires, M.D., Chairman of the ACS Graduate Medical Education Committee and Chairman of the ACS Board of Regents. The commission was directed to explore mechanisms of approval and accreditation of graduate education in all surgical disciplines. The report of this commission which is entitled, Proposal for a New Mechanism to Approve and Accredit Graduate Education (Residency Training) Programs in the Surgical Specialties begins on page 62. It was approved by the ACS Board of Regents in February 1980.

The report recommends the following:

1. Individual residency review committees for surgical specialties should function as the accrediting authority for graduate medical education under the authority of its appropriate sponsoring organizations. Each RRC should be an independent body and sponsored as a separate entity. Each RRC should reexamine its sponsorship and since the AMA (Council on Medical Education) is represented significantly at other levels of graduate medical education on the LCGME, its participation in the RRC would not seem to be necessary.

Comment:

These recommendations return the RRCs to their prior status as independent entities with their policies and procedures only subject to approval by their sponsoring organizations. A major change is to remove the AMA from participation in the surgical RRCs. The residency review committee in surgery was established as The Joint Conference Committee for Graduate Training in Surgery in 1950 under the auspices of the ACS and AMA and the American Board of Surgery. All RRCs established subsequently followed this pattern. Removing the AMA as a sponsor of surgical RRCs would not only preclude its appointing members to residency review committees, but it would no longer have approval authority over the Special Requirements for each surgical specialty.

2. An "Organization of Residency Review Committees" should be formed with a staff and office facilities separate from all existing organizations. This organization would provide the data collection, record keeping, accounting, and secretarial services required by the surgical RRCs. It would be staffed by "laymen". Site visits would be conducted by laymen or surgical specialists and surveys by "field staff" would be eliminated.

Comment:

The proposal to have a non-M.D. staff is consistent with the present experience with the AMA staff. LCGME and the RRCs are now largely staffed by non-M.D.s and an experiment is underway to have non-M.D.s conduct site surveys. The experience to date is very positive. However, the ACS plan for developing a separate staff does not include the LCGME. Discussion with Dr. Shires brought out that the LCGME would have its own separate staff. The LCGME would thus be isolated from the RRCs. Communication would be impeded. This concept of staffing is not surprising considering the limited role assigned to the LCGME in the proposal.

3. The cost of accreditation should be covered by revenues granted through charges to institutions and programs on annual per resident capitation basis and through charges for surveys and program evaluation.

Comment:

This proposal is consistent with the Executive Council's action at the January Council meeting

approving an LCGME recommendation that the accreditation system should be independently financed. The AMA and AHA have vetoed the recommendation.

4. The LCGME should be involved in the appeals process and develop the general requirements with approval by the CCME and the Organization of RRCs. It would also consult on the Structure and Functions document, but will have no role in the development or approval of the special requirements. It specifically would not participate in the governance of RRCs or the Organization of RRCs.

Comment:

This proposal would effectively isolate the LCGME and eliminate it as a meaningful entity. Its ability to function as an appeals body or have a significant role in the development of the general requirements or the Structure and Functions document is dubious.

The Future

It is difficult to predict how the current stresses in the accreditation system for GME will be relieved. The Association has supported several of the positions now put forth by the ACS as have the Council of Medical Specialty Societies and the American Board of Medical Specialties. However, the concept of removing the accrediting authority from the LCGME and isolating it in a liaison capacity with minimal responsibilities is not consistent with the Association's position of strong support for the LCGME and its original purpose and functions.

The ACS has set June 1980 as the time to have an implementation plan developed. Should the surgical specialties proceed to develop the ACS proposal, graduate medical education accreditation would be split, with seven or more RRCs functioning independently from the LCGME and the other RRCs. Informal conversations with ACS indicate that the proposal is not a fixed position. The CMSS plans an extensive discussion of the proposal at its meeting on March 18 and 19. Jack Myers has been asked to discuss the AAMC's Task Force recommendations at that meeting. The Steering Committee of the LCGME plans to meet with the ACS.

Considerations and Compromises

1. Residency Review Committee Composition

The Task Force on Graduate Medical Education recommended that the AMA no longer sponsor RRCs and that they be sponsored by specialty boards and national specialty societies. A compromise would be to have the AMA continue to appoint members to RRCs, but not have the

authority to ratify their special requirements.

2. LCGME Accreditation Authority and Relationships with RRCs

The Association has supported the LCGME as the final accrediting authority. This should continue and the authority of the LCGME to approve special requirements, develop the general requirements and be responsible for the Structure and Functions document should also continue. Some of the problems with communications between the RRCs and LCGME can be solved by more effective staff work. A compromise would be to provide for direct representation of RRCs on the LCGME. If four to six positions for RRC representatives were authorized, RRCs could appoint representatives on a rotational basis.

3. Financing

The current financing system places the AMA in the position of controlling the fiscal affairs of the LCGME and RRCs. The AMA essentially sets the budget, pays for one-half the costs, and offsets the balance from revenues from program charges and seat charges to the LCGME sponsors. The LCGME proposal for financing the accreditation system from revenues generated by charges to institutions and programs would place the LCGME and RRCs in control of their fiscal affairs. The Association should continue to support this position without compromise.

4. Staffing

This has been a major point of contention and its solution is difficult. Developing an independent staff without a base in another organization would be a major undertaking and obtaining the necessary records of the accreditation status of existing programs may be difficult to impossible. The LCCME has had great difficulty obtaining its records from the AMA. On the other hand, personnel whose hiring, firing and retiring are controlled by an organization will always be in an awkward position vis-a-vis their loyalty to that organization versus the LCGME.

The Association could continue to press for the development of an independent staff and separate facilities or it could: (a) ask for an independent staff which might be housed in and use the support facilities of one of the LCGME sponsors. For example, the American Medical Political Action Committee (AMPAC) is housed at the AMA in quarters which are clearly demarcated; (b) support the negotiation of a contract for services with one of the sponsors. This option would require control of its fiscal affairs by the LCGME and the development of a future program plan which could be analyzed in terms of staffing and support requirements.

The financing issues and the staffing issues do not appear to be separable and since a recommendation for independent financing of the accreditation system has been vetoed very recently by the AMA and the AHA, their resolution will be difficult.

Conclusion

Although the LCGME was established in a climate of cooperation and agreement, and its purposes and functions are both worthy and necessary, its operations have been impeded by disagreement and controversy amongst its sponsors and some of the sponsors' members. Despite many problems, the LCGME has had a positive effect on the accreditation of graduate medical education. Among its accomplishments are an improvement in the review process and better documentation and record keeping by the residency review committees. Much more needs to be done, but further progress depends upon a willingness amongst its sponsors to provide both the LCGME and the RRC the resources and latitude needed to accomplish the functions which were agreed to in 1972.

Addendum (March 25, 1980):

Subsequent to the dissemination of its proposal by the American College of Surgeons, the Graduate Medical Education Committee of the Council of Medical Specialty Societies met with representatives of the American College of Surgeons and the other specialty societies which make up the CMSS constituency. Twelve points of agreement were reached regarding residency review committees and the LCGME and presented to the Council of Medical Specialty Societies at their March 1980 meeting.

The twelve points include: a separate staff, independent financing, continuing the LCGME as the body having accrediting authority over graduate medical education, but delegating that authority to residency review committees subject to periodic review by LCGME, maintaining the current approval process for the General and Special Requirements, empowering residency review committees to develop variations of the Structure and Functions document suitable to their needs following an LCGME outline and subject to LCGME approval, having specialty societies be one of the sponsors of each residency review committee, and mandating approval of LCGME decisions by majority vote rather than permitting veto of policy decisions by one or more sponsoring organizations.

The CMSS is developing a formal proposal based upon the twelve points which will be acted upon at its next Assembly meeting in July 1980.

American College of Surgeons



1 EAST ERIE STREET CHICAGO, ILLINOIS 60611

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4 March 1977

Leonard D. Fenninger, M.D.
Secretary
Liaison Committee on Graduate Medical Education
535 North Dearborn Street
Chicago, Illinois 60610

Dear Dr. Fenninger:

The Board of Regents of the American College of Surgeons has received and unanimously approved a report from the American College of Surgeons Graduate Education Committee. This report expressed concern over present developments in U.S. medical education, and requested the Board of Regents to express formally the concern of the American College of Surgeons to various governing bodies in medical education. These include the Coordinating Council on Medical Education, with its parent organizations, the Liaison Committee on Graduate Medical Education, each of the American "surgical" specialty boards, and the parent organizations of these specialty boards.

The Graduate Education Committee is concerned with inappropriate activities and assumptions of the LCGME in its relations with the Residency Review Committees, with their parent organizations and with the CCME. These concerns are detailed below.

First, the LCGME has designated itself as the "accrediting agency" for all residency programs, a role that is actually served by the Residency Review Committees in their recommendation for approval or disapproval of residency training programs. There is not provided a direct appeals process at the interface between the LCGME and the Residency Review Committees. Moreover, the Residency Review Committees are incorrectly presumed to be capable of speaking to policy matters affecting their composition and function, when such matters are within the authority of the Residency Review Committees' sponsoring organizations. For example, the parents of the Residency Review Committees are being bypassed in the development of a new "Structure and Functions" document for the Residency Review Committees. Nor have they been consulted in proposed and recently enacted changes in financing of the Residency Review Committees. There has not been any formal contact with (at least one of) the previous sponsors of the Residency Review Committees before abandoning preexisting agreements for function of the Residency Review Committees.

American College of Surgeons

4 March 1977

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Thus, the LCGME in matters of policy ignores the ultimate power base for the Residency Review Committees.

Clarification is urgently needed on the relation between the LCGME and the CCME, the overall policy making body in U.S. medical education, speaking for its five parent organizations. It would be highly irregular if the LCGME should attempt to function as a body divorced from relation with the overall policy concerns of medical education addressed by the CCME, while paying inadequate attention to the practical questions properly raised by the Residency Review Committees, acting in accord with policies long established by their parent organizations.

The inadequacies of the LCGME as noted above are compounded by staffing that is not only insufficient and inefficient, but is formally related to one of the LCGME sponsoring organizations, introducing a bias in staff activity that would not exist with an independent staff.

The Board of Regents unanimously approved the following recommendations:

1. The Residency Review Committees should be designated as the approval bodies for graduate education "residency" programs -- in the surgical specialties.
2. All policy matters of the Residency Review Committees relating to the "Structure and Functions", approval of "Special Requirements" ("Essentials"), and the "Guide", should be approved by the active sponsoring organizations (parents) of the Residency Review Committees.
3. Active members of the Residency Review Committees should be selected and appointed to perform one function -- the evaluation of the quality of residency training programs in their specialty. Surgeons would thereby review and accredit the surgical training programs.
4. The LCGME should be designated as the appeals body for graduate education "residency" training programs in the surgical specialties, establishing policy questions in concert with input from the Residency Review Committees.
5. The CCME should define the relation between the CCME and the LCGME, and should review the relation of the LCGME to the Residency Review Committees, including the appeals process.
6. There should be a free-standing, independent staff for the LCGME and the Residency Review Committees. This staff should not be related in any way (i.e., housing, payment, accounting, or other) to any sponsoring organiza-

American College of Surgeons

4 March 1977

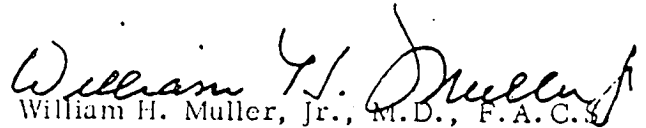
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tion of the LCGME, the CCME, or the "parents" of the Residency Review Committees.

7. Organizations sponsoring the LCGME, such as the Council of Medical Specialty Societies and the American Board of Medical Specialties (multi-disciplinary in their organization) should not be responsible for policy questions regarding graduate education in surgery "residency" programs. This should continue as it was prior to January 1975, when the responsibility was held by the individual specialty groups as sponsors of the Residency Review Committees.

The Board of Regents is requesting the Board of Trustees of the AMA to reevaluate the process by which the AMA approves policy matters relating to the Residency Review Committees, such as revision of the "Special Requirements". Their current procedure has resulted in excessive delays regarding some policy matters relating to the Residency Review Committees.

Sincerely,



William H. Muller, Jr., M.D., F.A.C.S.

Chairman

Board of Regents

WHMJr/lk

American College of Surgeons



55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611

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5 December 1977

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

Dear Dr. Fisher:

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

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

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

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

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

American College of Surgeons

Russell S. Fisher, M.D.

5 December 1977

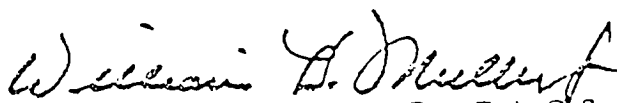
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- b. receive independent staffing
 - c. include a number of voting members (preferably three) with service on the Specialty Boards or Residency Review Committees.
2. That the individual Residency Review Committee for each of the several surgical specialties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

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

I am looking forward to a definitive response.

Sincerely,



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

WMM:JRS

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

Office of the Secretary

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Member Organizations

American Board of Medical Specialties
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American Hospital Association
840 N. Lake Shore Dr., Chicago, Ill. 60611
American Medical Association
535 N. Dearborn St., Chicago, Ill. 60610
Association of American Medical Colleges
One DuPont Circle, N.W., Washington, D.C. 20036
Council of Medical Specialty Societies
P.O. Box 70, Lake Forest, Ill. 60045

13 February 1978

William H. Muller, Jr., MD, FACS
Chairman, the Board of Regents of the
American College of Surgeons
55 East Erie Street
Chicago, Illinois 60611

Dear Doctor Muller:

This letter is written in response to your letter of December 5, 1977, and addresses the items presented in your letter of March 4, 1977. Items addressed in the March 4 letter have been the subject of discussion by members of the LCGME during the intervening period. Dr. Russell Fisher, immediate past chairman of the LCGME, devoted a great deal of his time and effort to the improvement of communications with the Residency Review Committees. It is our belief, and that of the Residency Review Committee representatives to whom we have spoken, that this has been a mutually beneficial effort. The effort will be continued in the future.

To address the items in your March 4 letter specifically, we refer to the initial agreements of January 25, 1972 and March 30, 1972. You have indicated your awareness of these documents and while you state they do not contain answers to your questions, they do establish the basis upon which the Liaison Committee on Graduate Medical Education exists and functions.

Your specific proposal and our comments are as follows:

1. "The RRCs should be designated as the approval bodies for graduate education in residency programs in surgical specialties."

Comments: The LCGME was delegated the responsibility for accreditation in January 1972 and undertook that responsibility in January 1975. It was not and is not the intent of the LCGME to usurp the function of the RRC.

The RRCs are the approval bodies for graduate medical education. The LCGME accredits, as stated in the above paragraph, based upon the recommendations of the Residency Review Committees. The LCGME is now reviewing programs for consistency with published general and special requirements ("essentials") and for consistency of documentation with RRC recommendations. The Residency Review Committees in the various specialties conduct the substantive review of the educational programs in their appropriate specialties.

2. "All Policy matters of the Residency Review Committees relating to the 'Structure and Functions', approval of 'Special Requirements' ('Essentials'), and the 'Guide', should be approved by the active sponsoring organizations (parents) of the Residency Review Committees."

Comments: The LCGME reviews and approves "Special Requirements" and "Guides" only after the approval by the sponsoring organizations of the RRCs and on notification from the RRCs that they have been approved by said parents: "Structure and Functions" documents are circulated to the parent organizations of the LCGME and to all RRC members and are acted on by the LCGME after receipt of comments and recommendations.

3. "Active members of the Residency Review Committees should be selected and appointed to perform one function -- evaluation of the quality of residency training programs in their specialty. Surgeons would thereby review and accredit the surgical training programs."

Comments: Residency Review Committee members are appointed by the sponsoring organizations on the basis of their knowledge of their specialty and their knowledge of education and practice. Therefore, as stated above, specialists in their field do perform the substantive review and approval of each program.

4. "The LCGME should be designated as the appeals body for graduate education 'residency' training programs in the surgical specialties, establishing policy questions in concert with input from the Residency Review Committees."

Comments: The LCGME has been designated as the appeals body for residency programs, and has established a procedure for appeals which has been reviewed by all the Residency Review Committees. A copy of the appeals procedure is attached. The appeals procedure is now in operation.

5. "The CCME should define the relation between the CCME and the LCGME, and should review the relation of the LCGME to the Residency Review Committees, including the appeals process."

Comments: The CCME has reviewed the bylaws of the LCGME which include the function of the LCGME in relation to the Residency Review Committees and to the CCME. This includes the appeals mechanism. The CCME has forwarded the LCGME bylaws to the sponsoring professional organizations of CCME and they have been approved by all of these organizations.

6. "There should be a free-standing, independent staff for the LCGME and the Residency Review Committees. This staff should not be related in any way (ie: housing, payment, accounting or other) to any sponsoring organization of the LCGME, the CCME, or the 'parents' of the Residency Review Committees."

Comments: The LCGME has discussed this matter at great length, and has forwarded to the CCME and the parent bodies a proposal that "the sponsoring professional organizations establish a body external to the LCGME and representing senior offices of each organization to review the original articles of agreement in light of the subsequent experience of the LCGME".

7. "Organizations sponsoring the LCGME, such as the Council of Medical Specialty Societies and the American Board of Medical Specialties (multi-disciplinary in their organization) should not be responsible for policy questions regarding graduate education in surgery 'residency' programs. This should continue as it was prior to January 1975, when the responsibility was held by the individual specialty groups as sponsors of the Residency Review Committees."

Page four
William H. Muller, Jr., MD, FACS
13 February 1973

Comments: The individual specialty boards are sponsors of Residency Review Committees in each respective recognized specialty. Specialty societies are sponsors of Residency Review Committees in twelve specialties. The American College of Surgeons appoints members to residency Review Committees in seven specialties. The American Medical Association, through its Council on Medical Education, continues to be a sponsor of all Residency Review Committees.

The development and adoption of educational policies and standards have been described above. The American College of Surgeons, the American Boards of the several surgical specialties and the American Medical Association must approve special requirements for accredited residency programs and "Guides" in the seven fields in which the American College of Surgeons sponsors Residency Review Committees.

The question as to whether the Council of Medical Specialty Societies represents the individual specialty boards cannot be resolved by the Liaison Committee on Graduate Medical Education.

Comments directed towards specific points of your December 5 letter seem to be included above, plus the following.

There are currently six members of the LCGME who have service on specialty boards and/or Residency Review Committees.

The bylaws of the LCGME provide that general requirements be prepared by the LCGME and approved by CCME and its five parents. The present draft revision of general requirements has been circulated to all Residency Review Committees and sponsoring professional organizations. We, of course, invite and welcome comments by the American College of Surgeons. When all comments have been received, a final version will be submitted to the LCGME for approval and forwarding to CCME.

Page five
William H. Muller, Jr., MD
13 February 1978

The items raised are of importance, and are the subject of continuing discussion within the LCGME and the Residency Review Committees with which it works. It is my hope that the above statements clarify the current position of the LCGME.

Yours sincerely,

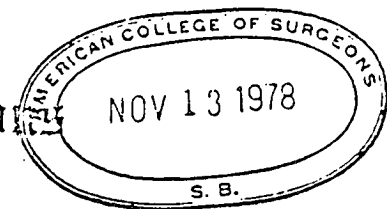


William K. Hamilton, MD
1978 Chairman, Liaison Committee
for Graduate Medical Education

enclosure

cc: Executive Officers, Parent
Organizations of LCGME
Secretary, LCGME
Chairmen - RRCs Surgical Specialties

American College of Surgeons



55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611

AREA CODE 312 - 664-4050 CABLE: AMERCOLSUR

November 7, 1978

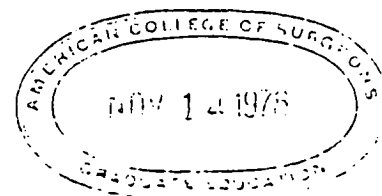
William K. Hamilton, M.D.
Chairman, Liaison Committee
on Graduate Medical Education
535 North Dearborn Street
Chicago, Illinois 60610

Dear Dr. Hamilton:

The American College of Surgeons has been concerned with the relations between the surgical Residency Review Committees, the parents of these Residency Review Committees, and the Liaison Committee on Graduate Medical Education. This concern was recorded in letters from the Chairman of the Board of Regents of the American College of Surgeons, dated March 4, 1977 and December 5, 1977. The Chairman of the Board of Regents received your response, as Chairman of the LCGME, which was dated February 13, 1978.

The Graduate Education Committee of the College reported to the Board of Regents in October, that the American College of Surgeons has not received a satisfactory response to the problems and recommendations presented in the March 4 and December 5, 1977 letters. The Board of Regents, on October 20, 1978, authorized the following actions:

1. The College Graduate Education Committee will appoint an Ad Hoc Committee from its membership, to explore a new mechanism for the approval of graduate education programs in the surgical specialties since a satisfactory response had not been received from the LCGME or the Coordinating Council on Medical Education to the previous communications of March 4 and December 5, 1977.
2. The American College of Surgeons, as a parent organization of seven Residency Review Committees, submits the following specific requests to the LCGME:



- a. that all actions of the LCGME be communicated to the parent organizations of the Residency Review Committees, by the LCGME;
- b. that a moratorium be placed on any further revisions of the "Manual of Structure and Functions for Residency Review Committees" until such revisions have been approved by the parent organizations of the Residency Review Committees, as well as the parent organizations of the LCGME, thus reverting to the document which was dated and effective July 1, 1976;
- c. that the approval of the parent organizations of the LCGME be required for the appointment of staff to serve the LCGME and that assent of the parent organizations of the Residency Review Committees be required for the appointment of staff to serve the Residency Review Committees.

Sincerely yours,

G. Tom Shires, M. D., F.A.C.S.
Chairman, Board of Regents

cc: C. Rollins Hanlon, M.D., F.A.C.S.
Director, A.C.S.

Frank Padberg, M.D., F.A.C.S.
Assistant Director, A.C.S.

Richard S. Wilbur, M. D.
Executive Vice President, C.M.S.S.

bcc: William K. Hamilton, M. D.
Department of Anesthesiology
Univ. of California School of Medicine
San Francisco, California 94143

American College of Surgeons



55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611

AREA CODE 312 - 664.4050 CABLE AMERCOLSUR

February 5, 1980

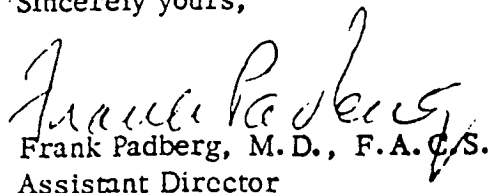
Richard S. Wilbur, M.D.
Executive Vice-President
Council of Medical Specialty Societies
P. O. Box 70
Lake Forest, Illinois 60045

Dear Dr. Wilbur:

I have been asked by the Board of Regents to forward to you the enclosed copy of a "Proposal for a New Mechanism to Approve and Accredite Graduate Education (Residency Training) Programs in the Surgical Specialties." This proposal was approved by the Board of Regents on February 3, 1980. It is requested that you submit this proposal, which is within the framework of the LCGME, to the members of your organization and other interested groups.

Background information relating to this proposal, letters of March 4, 1977 and December 5, 1977 from Dr. William H. Muller, Jr., then Chairman of the Board of Regents, and a letter of November 7, 1978 from Dr. G. Tom Shires, current Chairman of the Board of Regents, is also enclosed.

Sincerely yours,


Frank Padberg, M.D., F.A.C.S.
Assistant Director

FP/lk
Enclosures (4)

American College of Surgeons



55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611

AREA CODE 312 — 664.4050 CABLE: AMERCOLSUR

At the October 1979 meeting of the Board of Regents, the following resolution was unanimously approved:

Be it resolved:

that the Graduate Education Committee of the American College of Surgeons recommends to the Board of Regents the establishment of an ad hoc commission to explore mechanisms of approval and accreditation of graduate education in all surgical disciplines, within the framework of the Liaison Committee on Graduate Medical Education if possible; and

that this commission be charged with the responsibility for a preliminary report and statement of position by February 1, 1980, and a recommendation for implementation of this stated position by June 1, 1980.

The Executive Committee of the Graduate Education Committee prepared the agenda for the December 14, 1979 meeting of the ad hoc commission. A representative of each surgical specialty discipline participated. An open, general discussion provided the basis for the following statement of position and report on possible mechanisms to be used in the approval of graduate education programs in all the surgical specialty disciplines.

Proposal for a New Mechanism to Approve and Accredite Graduate Education (Residency Training) Programs in the Surgical Specialties

The individual Residency Review Committee representing a surgical specialty shall function as the accrediting authority for graduate education, under the auspices of its appropriate sponsoring organizations. The Residency Review Committee will develop and implement all its policy documents with a free-standing

staff, independent of any existing organization.

The Residency Review Committees representing the surgical specialties should collectively organize into a new and independent body (corporation) -- "The Organization of Residency Review Committees," with a staff and office facilities independent of all existing organizations. This corporation would be under management by and for the participating Residency Review Committees.

This Organization of Residency Review Committees' administrative headquarters, functioning with a centralized computer capability administered by a full-time staff, would maintain all Residency Review Committee records, coordinate information on the status of individual programs including data on program review and reporting of status to programs. The "Organization" would, with the Residency Review Committees, develop and implement standardized billing charges. It would manage the financial aspects of both the "Organization" and the individual Residency Review Committees; both must be financially self-sustaining. The income for support of these activities would be provided from annual capitation charges to the program per resident, including charges for lay and professional surveys and program evaluation. The schedule of charges would be reviewed, and the fees would be adjusted on an annual basis. In performing its work, the financial management would be required to function with a clear, fully descriptive budget and a full-disclosure financial statement.

Each Residency Review Committee would be an independent body set up under the sponsorship of its parent organizations as a separate entity. The "Organization" would be separately incorporated and have its governing trustees or directors elected or appointed by the Residency Review Committees. The Residency Review Committees would delegate certain functions to the "Organization." Each Residency Review Committee would utilize the "Organization's" lay staff to gather, collate, record, and report pertinent information for the Residency Review Committee, and to communicate with the individual programs. Specialists would make the professional site visits, upon recommendation of the Residency Review Committee. This would eliminate the "field staff" surveys.

Each Residency Review Committee must reexamine its structure (parents) and restructure itself where appropriate, in consultation with other organizations that maintain a major commitment to graduate education in that discipline. The Residency Review Committee, when restructured as an independent body, will have its representative sponsors (trustees) considering the policy and other matters, under majority rule. Since the American Medical Association (Council on Medical Education) is represented significantly at other levels in graduate medical education on the LCGME, its participation in the Residency Review Committee would not seem to be necessary.

One role for the LCGME could be involvement in the appeals process. It should, in addition, develop the broad, general "Essentials" common to all graduate medical education, which could be adopted by the "Organization," under

the Coordinating Council on Medical Education (CCME). The LCGME could assume a consultative status with the "Organization" in the development of statements relating to the "Structure and Functions" document. The Organization of Residency Review Committees would develop and implement the "Structure and Functions" document for the Residency Review Committees. The "Organization" could assume a consultative status for the preparation of the "Special Requirements," which would be developed by and implemented by each individual Residency Review Committee, an independent body under its sponsors. The LCGME would not participate in the "governance of the Residency Review Committee."

The activities of the "Organization" would accomplish what the LCGME has been doing in the past in meeting with the Chairmen of the Residency Review Committees. Further, the LCGME would be functioning in a liaison capacity. It could conduct this function with a small staff, thus diminishing expense significantly.

The CCME could continue its function as the coordinator of all medical education.

Approved by
ACS Board of Regents
February 3, 1980

Liaison Committee on Continuing Medical Education

Background

The parent organizations of the CCME agreed in November 1974 to establish a Liaison Committee on Continuing Medical Education (LCCME). The first organizational meeting of the new committee was held on November 20, 1975. The agreed upon membership was as follows:

American Board of Medical Specialities (ABMS)	3
American Hospital Association (AHA)	3
American Medical Association (AMA)	4
Association of American Medical Colleges (AAMC)	3
Council of Medical Specialty Societies (CMSS)	3
Association of Hospital Medical Education (AHME)	1
Federation of State Medical Boards (FSMB)	1
Representative of the Public	1
Federal Representative	1

On July 1, 1977 the LCCME took over the accreditation function from the AMA. The staffing of the LCCME was provided by the AMA. Funding of the LCCME was from two sources : (a) shared cost assessment on a per seat basis for the LCCME meetings (policy function), and (b) the income derived from accreditation fees and deficit guarantee by AMA for surveys, review committee meetings and record keeping (accreditation function).

With minor delays and confusion the transfer of the accreditation function proceeded smoothly. Policies and procedures established originally by the AMA continued to be applied by the LCCME. This included the delegation of the survey function for all organizations and institutions offering continuing medical education of local character to the respective State Medical Societies.

From the onset of LCCME activities, there were diverse opinions concerning the extent to which the LCCME should engage in a fundamental review of the concept of quality in continuing medical education and the role of accreditation in assuring it. The AAMC representatives contended that this should be a task of high priority and an affirmative position was taken by the LCCME in September 1977. This task was then assigned to the Goals and Priorities Subcommittee of the LCCME under the chairmanship of William D. Mayer who also chaired at that time the AAMC Ad Hoc Committee on Continuing Medical Education. Policy recommendations of the Subcommittee that were adopted by the LCCME between March 1978 and June 1979 included: (a) development of new Essentials based on a set of "Principles for Continuing Medical Education"; (b) a firm commitment to delegate the authority for accrediting institutions and organizations providing continuing medical education of local character to state organizations, and (c) achievement of financial independence by the LCCME.

The AAMC's Ad Hoc Committee on Continuing Medical Education realized that implementation of these tasks would require a major effort and responded favorably to a suggestion by Bill Mayer that AAMC and the Veterans Administration combine their interest in this area by developing a joint project. A proposal for a project to develop principles and criteria of quality for continuing education of health professionals based on educational and systems foundations was developed and funded in September 1978. The project further was to develop resource materials required to apply these principles and criteria and to pilot test them in a number of VA hospitals and elsewhere if the interest should become apparent. The intent was for project staff at AAMC to consider the priorities and interests of the LCCME.

AMA Action

The AMA decision to withdraw from the LCCME came to most as a surprise, although it was at times hinted at in a joking manner. At its July 19-23, 1979 meeting the AMA's Council on Medical Education considered and approved a staff report, "Report I", regarding the "Role of the AMA in the Accreditation of Medical Education" containing among others a recommendation that the AMA withdraw from the LCCME and assume the responsibility of accreditation of continuing medical education by simultaneously recognizing the state medical associations as the accrediting bodies for institutions and organizations offering local programs.

Report I, including its recommendations, was subsequently approved unanimously by the Board of Trustees. On July 23 the Reference Committee C of the House of Delegates heard testimony on Report I as well as resolutions proposed by the Massachusetts and Arizona delegations. Most statements during this meeting were against an immediate withdrawal, and the Reference Committee recommended postponement of the final decision for six months. However, on July 25 the House of Delegates voted approval of Report I and its recommendations.

On July 30, an AMA memorandum informed all institutions and organizations accredited for continuing medical education of the AMA's withdrawal from the LCCME and recognized their accreditation as of July 25, 1979. In another memorandum, the State and Territorial Medical Associations were advised that AMA would recognize them as the accrediting bodies within their respective states or territories. Finally, Dr. James Sammons requested nominations for membership on a new Committee on Accreditation of Continuing Medical Education of the Council of Medical Education of the AMA from the members of the AMA Federation, from the AHA, AHME, FSMB, and the specialty boards. This Committee has met during the winter and has recommended accreditation decisions to the Council on Medical Education of the AMA.

LCCME Actions

In response to this unilateral action by the AMA, the chief executive officers of the remaining member organizations of the LCCME met and unanimously agreed that:

- a national broadly representative organization was essential for accreditation in continuing medical education;

- the establishment of two competing accreditation agencies was deplorable but unavoidable and every effort should be made for reconciliation;
- the withdrawal of one member from a voluntary partnership or association does not dissolve the partnership;
- the LCCME should reorganize its staffing and financial basis and should continue its accreditation function;
- the accreditation records should be considered the legitimate property of the LCCME.

At a subsequent meeting in early September the LCCME reaffirmed the positions stated in the above conclusions. It agreed to a staffing contract with CMSS, Dr. Richard Wilbur assuming the position of Secretary of the LCCME; it prepared a budget for approval by its parent institution including a request for a per seat contribution; and it began to organize procedures for continuing its accreditation function.

The LCCME was, and still is, greatly handicapped by AMA's contention of being the sole and rightful owner of the LCCME records under the assumption that the LCCME had ceased to exist following AMA's withdrawal from the Committee. The LCCME therefore has depended on piecemeal communication with accredited organizations and institutions, and on incomplete data regarding pending applications, reaccreditation dates, etc.

In general, the response to AMA's action has been one of dismay. Many groups, among them the Midwestern/Great Plains Meeting of Deans, have urged efforts at reconciliation. The resolution adopted by that Section of the Council of Deans was subsequently adopted by the AAMC Executive Committee (attached). The LCCME therefore has restrained from taking aggressive action, e.g. it has postponed a decision about whether to sue the AMA for the transfer of records, and instead has taken the more tedious route of depending on every accredited institution to request transfer to the LCCME of its records at AMA. Also, in contrast to AMA, which has disseminated doubts about the LCCME's continuing existence, and advised State Medical Societies not to work with the LCCME, the LCCME has refrained from aggressive communication statements.

Present Situation

The LCCME has resumed its accreditation function while depending on the initiatives of accredited institutions and organizations to have copies of their records transferred from AMA. Of all medical schools so far, records of only 33 have been received by the LCCME offices. In toto, the LCCME has presently records of about 120 organizations. This is short of the approximately 500 accredited institutions and organizations. At its last meeting the LCCME made accreditation decisions regarding 16 applications. Of the 50 state organizations, fifteen have decided to communicate their accreditation decisions to the LCCME, i.e. to act as an accrediting agent of the LCCME.

Nine states have decided not to relate to the LCCME; the balance appear to be undecided. Most state licensing boards apparently plan to accept both LCCME and AMA accreditation where credits of physicians are required for relicensure. One specialty society has indicated it will not recognize AMA accreditation.

The LCCME seems to be progressing rapidly rewriting the Essentials and developing new guidelines and procedures for accreditation. For this effort it relies heavily on both AAMC and CMSS participation and the results of the AAMC/VA project.

Necessary Actions

For the LCCME to be able to carry out its function it requires the support of the member organizations and of accredited institutions and organizations. The AAMC Executive Council believes that support of the LCCME is in the interest of continuing medical education and of the medical schools as providers. It is therefore important that all medical schools which have not yet done so, request from AMA the transfer of copies of their accreditation records to the LCCME. Such requests should be addressed to: Ralph E. DeForest, M.D., Director, Department of Continuing Medical Evaluation, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. The medical schools should further communicate with the LCCME and seek its accreditation. They should consider whether the accreditation by AMA is essential for their programs. If it is not, they should decline it.

Medical schools could further support the LCCME by urging their respective medical societies and medical licensure boards to recognize the LCCME as the national agency for the accreditation of CME and transmit their accreditation decisions to the LCCME. The LCCME must proceed as rapidly as possible to consolidate its position. It should develop its new Essentials, guidelines and procedures as soon as possible. These are necessary for assuring the quality of CME offered to physicians by all recognized institutions and organizations involved in continuing medical education. Also, the LCCME and its parent members should continue to work toward the goal of one voluntary accrediting body for continuing medical education.

March 26, 1980

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Executive Committee Minutes
November 8, 1979
Washington Hilton Hotel
Washington, D. C.

Present: Dr. Stuart Bondurant Dr. Richard Knapp
 Mr. John Colloton Dr. Thomas Oliver
 Dr. John Cooper Dr. John Sherman
 Ms. Kat Dolan Mr. Charles Womer

The Executive Committee met at 1:30 p.m. to consider a resolution presented by Dr. Stuart Bondurant, on behalf of the Midwest-Great Plains Section of the Council of Deans.

ACTION: *On motion, seconded, and carried, the Executive Committee adopted the following resolution:*

Believing that a single national system for accrediting continuing medical education programs which includes appropriate representation of the public and affected segments of the medical profession is in the public interest; be it therefore resolved that the Executive Committee of the Association of American Medical Colleges urges that the AAMC, the AMA Section on Medical Schools, the Federation of State Medical Boards, the American Medical Association, as well as all other members of the Liaison Committee on Continuing Medical Education direct all good offices at their disposal toward the achievement of this goal.

The meeting adjourned at 1:35 p.m.

THE NATIONAL BOARD OF MEDICAL EXAMINERS

The National Board of Medical Examiners was established in 1915 by joint action of the AAMC, AMA, the American College of Surgeons, and the Federation of State Medical Boards. Later representatives from other organizations concerned with medical education, and members-at-large, were added to the Board. There are now 73 members (see page 72). The AAMC has two representatives on the Board which meets once per year.

During the past year several concerns have evolved about NBME policies and procedures relative to three areas of significant interest to the medical schools and their faculties.

I. Proposed Changes in Governance:

At the annual meeting on March 20-21, 1980, the report of a governance committee was presented for approval (see page 74). The Board debated and approved most of the recommended changes in composition and governance. These changes will have to be incorporated into the by-laws. Amendments to the bylaws will have to be approved at the next meeting of the Board by three fourths of the members attending. A mail ballot approval (which is provided for in the NBME's bylaws) was ruled out by a vote of the Board at the annual meeting.

Of particular concern are the following:

COMPOSITION

	<u>Present</u>	<u>Proposed</u>
Ex-Officio	33	12
Members Nominated by Other Organizations	19	25
Members-at-Large	20	42 (to include 15 members drawn from present or immediate past test committee chairmen or members and 5 public members)
Honorary	<u>1</u>	<u>1</u>
TOTAL	73	80

The major concerns are the reduction in ex-officio members by removing test committee chairmen from ex-officio status and having representatives from test committees selected by the nominating committee in the members-at-large category. A test committee chairman at the meeting expressed the belief that this would denigrate the role of the test

committees in the NBME and could lead to difficulties in recruiting chairmen and members from the faculties.

DESIGNATION OF EXECUTIVE COMMITTEE AS EXECUTIVE BOARD

The Executive Committee is to be designated the Executive Board with the following changes in composition.

<u>Present</u>		<u>Proposed</u>
Chairman of the Board		Chairman
Immediate Past Chairman		Immediate Past Chairman
9 Vice Chairman		10 Vice Chairman
Treasurer		Treasurer
Five Members-at-Large		President
		Five Members-at-Large
	Non-Voting	
3 Vice Presidents		Non-Voting
Secretary		
		None

The major change in composition is the elimination of the ex-officio non-voting positions and making the President a voting member. Of significant concern is the change in name. The Executive Committee already functions with great autonomy. If designated the Executive Board of the Board, the confusion as to where policy authority and responsibility lies will be increased. Further, in the committee proposal, the President was made accountable only to the Executive Board. Accountability to the NBME was added by floor amendment.

The thrust of the proposed changes in governance appear to be to centralizing the authority and responsibility in the Officers and Executive Committee with the Board itself and the organizations which have a vital interest in the Board's activities relegated to a passive informational role.

NATIONAL BOARD OF MEDICAL EXAMINERS MEMBERSHIP

Member	Term Expires	Representation
William D. Holden, M.D.	1981	Chairman
William D. Mayer, M.D.	1981	Vice Chairman
James E. Eckenhoff, M.D.	1981	Treasurer
John S. Millis, Ph.D.		Past Chairman
Robert A. Chase, M.D.	1981	Executive Committee
C. William Daeschner, Jr., M.D.	1981	Executive Committee
Howard L. Horns, M.D.	1981	Executive Committee
John H. Morton, M.D.	1981	Executive Committee
Roy C. Swan, M.D.	1980	Executive Committee
Edithe J. Levit, M.D.		President
David E. Smith, M.D.		Vice President and Secretary
Fredric D. Burg, M.D.		Vice President
DeWitt C. Baldwin, Jr., M.D.		Test Committee Chairman
Elizabeth Barrett-Connor, M.D.		Test Committee Chairman
Angelo M. DiGeorge, M.D.		Test Committee Chairman
Thomas F. Ferris, M.D.		Test Committee Chairman
Fairfield Goodale, Jr., M.D.		Test Committee Chairman
Ward O. Griffen, Jr., M.D.		Test Committee Chairman
Jan Langman, M.D., Ph.D.		Test Committee Chairman
Wallace T. Miller, M.D.		Test Committee Chairman
Frederick D. Neidhardt, Ph.D.		Test Committee Chairman
Roger F. Palmer, M.D.		Test Committee Chairman
Henry Z. Sable, M.D., Ph.D.		Test Committee Chairman
Morton A. Stenchever, M.D.		Test Committee Chairman
Arthur J. Vander, M.D.		Test Committee Chairman
George D. Webster, M.D.		Test Committee Chairman
Peter C. Whybrow, M.D.		Test Committee Chairman
John P. Hubbard, M.D.		President Emeritus
Colonel John C. Richards (MC) USA	1980	U.S. Army
RAdm. J. William Cox (MC) USN	1980	U.S. Navy
Colonel Thomas P. Ball, Jr. (MC) USAF	1984	U.S. Air Force
Henry A. Foley, Ph.D.	1982	Department of HEW
John A. Mather, M.D.	1984	Veterans Administration

C.H. William Ruhe, M.D.	1980	AMA
Joseph M. White, M.D.	1980	AMA
Joe S. Greathouse, Jr., M.D.	1981	AHA
David A. Gee	1982	AHA
Carmine D. Clemente, Ph.D.	1980	AAMC
August G. Swanson, M.D.	1980	AAMC
John W. Beeler, M.D.	1981	CMSS
Paul J. Fink, M.D.	1981	CMSS
Glen R. Leymaster, M.D.	1983	ABMS
John C. Beck, M.D.	1982	ABMS
Sheldon Sevinor, M.D.	1981	PNHA
R. James Brenner, M.D.	1982	AMA-RPS
Rocio Huet-Rose	1982	AMSA
Lawrence S. Brown, Jr.	1983	SNMA

33
ex-officio

19
other orga-
nizations

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NATIONAL BOARD OF MEDICAL EXAMINERS MEMBERSHIP
PAGE TWO

Member	Term Expires	Representation
Richard E. Flood, M.D.	1984	Federation of State Medical Boards
Bryant Galusha, M.D.	1981	Federation of State Medical Boards
Lawrence Scherr, M.D.	1980	Federation of State Medical Boards
Harold E. Wilkins, M.D.	1981	Federation of State Medical Boards
Edgar W. Young, Jr., M.D.	1980	Federation of State Medical Boards
Stephen Abrahamson, Ph.D.	1982	Member-at-Large
Arthur E. Baue, M.D.	1983	Member-at-Large
Gordon H. Deckert, M.D.	1983	Member-at-Large
Floyd W. Denny, Jr., M.D.	1980	Member-at-Large
Robert C. Derbyshire, M.D.	1980	Member-at-Large
Harold S. Ginsberg, M.D.	1983	Member-at-Large
Harold G. Jacobson, M.D.	1983	Member-at-Large
Richard Janeway, M.D.	1983	Member-at-Large
Susan A. Kline, M.D.	1981	Member-at-Large
Marion Mann, M.D.	1980	Member-at-Large
Edward R. Perl, M.D.	1980	Member-at-Large
Thomas E. Piemme, M.D.	1980	Member-at-Large
Jay P. Sanford, M.D.	1983	Member-at-Large
Jarry Schwartz, Ph.D.	1983	Member-at-Large
Richard W. Stander, M.D.	1980	Member-at-Large
Robert B. Stevens	1983	Member-at-Large
Rosemary A. Stevens, Ph.D.	1983	Member-at-Large
Louis Sullivan, M.D.	1981	Member-at-Large
Joseph F. Volker, D.D.S., Ph.D.	1981	Member-at-Large
Robert Volle, Ph.D.	1981	Member-at-Large
Jack D. Myers, M.D.		Honorary Member

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REPORT OF THE EXECUTIVE COMMITTEE TO THE NBME
ON GOVERNANCE OF THE BOARD

At a meeting of the Executive Committee of the NBME in November of 1978, an action was taken that directed the Chairman to appoint a committee "to study the governance and organizational structure of the Board and the appropriate participation of related groups, organizations, and institutions in the activities of the Board."

Following that meeting, the Chairman requested the President to develop in part as background for the committee's use, a statement depicting the mission, goals, and objectives of the Board and the current trends in medical education, licensure, and certification that could have an impact upon the services provided by the NBME. This report was presented to the National Board at its Annual Meeting in March 1979. The Ad Hoc Committee on Governance and Organizational Structure was appointed in April 1979 and consisted of Dr. Ray L. Casterline, Dr. Robert H. Ebert, Dr. John S. Millis, Dr. C.H. William Ruhe, Dr. Vernon E. Wilson, Dr. Edithe J. Levit, Dr. William D. Holden, as Chairman, and Mrs. Alice J. Wooden as staff for the committee.

The Committee met on two occasions, reviewed a considerable amount of information provided by the staff, discussed in depth the issues confronting the Board in the context of the charge to the Committee, and submitted two reports. One, which contained suggestions relating to the structure of the full-time staff of the Board, was transmitted to Dr. Levit for her consideration. The other report contained numerous recommendations relating to the governance of the Board. This was discussed at great length by the Executive Committee at its meeting on October 15-18, 1979. As a result of the Executive Committee's further discussion and action at its January 1980 meeting, several of the Governance Committee's recommendations were modified and some deleted.

The following represents the Executive Committee's recommendations to the NBME on the governance and organizational structure of the National Board. Each recommendation is preceded by a statement of the basis or background for the recommendation.

A) STRUCTURE OF THE BOARD

Membership

The National Board of Medical Examiners (NBME) holds a unique position among the national organizations related to education and care in the health professions. It has functioned independently and as such has had the privilege of devising and implementing innovations that have had a constructive impact upon the process of evaluation.

Membership

The NBME should preserve its independence by addressing appropriately its composition and the mechanisms employed for the nomination and election of new members.

Composition

The NBME from the time of its establishment has had members who have been nominated by national professional organizations and the federal services. This

continuing liaison with these organizations has been a source of strength for the NBME. The members-at-large have consistently represented individuals with particular expertise, experience, or professional relationships who provide the NBME with a wide variety of perspectives and abilities required for the comprehensive and effective operation of the NBME. Up to the present, test committee chairmen have been ex officio members of the NBME. Because of the heavy commitments of the test committee chairmen both to the NBME and to other academic institutions, it appeared desirable to permit greater flexibility in obtaining representatives from the test committees by eliciting nominations of past or present test committee chairmen or members. Each would be elected as a member-at-large permitting members of the test committees to have a full term as a member of the National Board of Medical Examiners in contrast to the ex officio status that presently exists and interrupts the tenure of test committee members.

Composition

- (1) The composition of the NBME should assure a distribution of members who have responsibility and expertise in the multiple areas of health professions education, medical practice, and evaluation; national professional organizations including those representing medical students and housestaff; client organizations; the public; and individuals participating in the design and construction of examinations.
- (2) The NBME should have the following types and numbers of members.

Ex officio members

(a) With Vote

The Executive Board; Chairman of Examination
Committee Chairmen; John P. Hubbard

Subtotal 12

(b) Without Vote

Honorary members

Subtotal (1)

Members nominated by other organizations

FSMB (5), AMA (2), AAMC (2), AHA (2), CMSS (2), ABMS (2),
PMA (1), AMA-RBS (1), SNMA (1), AMSA (1), Surgeons
General of Armed Forces (3), DHEW (1), VA (1), ECFMG (1)

Subtotal 25

Members-at-Large

Subtotal 42

Members-at-Large

Total 80

Members-at-large should include 15 members drawn from present or immediate past test committee chairmen or members of each NBME test committee and five public members.

Election

- (1) A broad base of individuals and organizations should be requested to submit suggestions for the nomination of new members of the NBME.
- (2) Members-at-large should be nominated and elected to the NBME so that multiple areas of experience and expertise not represented elsewhere in the membership are available.

B) THE EXECUTIVE BOARD

The membership of the NBME has attained such a size that the current Executive Committee does not function as a committee but is, in fact, the board of directors and should be called the Executive Board, which is a title applied to such an entity by parliamentary principles. The number and complexity of the issues confronting the Executive Committee in recent years have increased so that there has been of necessity an increment in the number of meetings required to address questions of policy.

Composition

The Executive Committee should be redesignated the Executive Board of the NBME and should be composed of the Chairman, Vice Chairman, Treasurer, Past Chairman, President, and five members-at-large. The Executive Board should be comprised of individuals representing multiple areas of expertise, responsibility, and experience.

Nomination and Election

Nominations for membership on the Executive Board, other than ex officio members, should be derived in a formal manner by the Nominating Committee from several sources. The members of the Executive Board should be elected by the NBME upon nomination.

Meetings

The Executive Board should hold four regularly scheduled meetings a year and others at such time and place as it may determine or upon call of the Chairman of the Board or upon written request of two of its members.

C) COMMITTEES

The committee structure of the NBME is an invaluable asset and the deliberations and recommendations of the several committees are frequently the source of change in policy that is transmitted to the Executive Board and the NBME. Depending upon the site of authorization for the establishment, continuance, or discontinuance of a committee, it may report to the NBME itself, the Executive Board, or the President.

The desirability of a broad input of suggestions for the Nominating Committee and the provision of pertinent information to the Committee concerning the types of expertise and experience needed by the NBME are apparent.

A more formal and more organized effort to obtain the advice and counsel of test committee chairmen concerning policy related to evaluation services and other matters should enhance the NBME's capability to identify and implement new and different test instruments that would improve the relevance, reliability, and validity of its services.

Finance Committee

- (1) The Finance Committee should consist of four or more members of the NBME, one of whom is the Treasurer and the others appointed by the Chairman of the Board. The committee should review the annual budget of the NBME and recommend its adoption to the Executive Board and to the NBME. The committee should advise the Executive Board and the NBME concerning the financial status of the NBME and, upon request, advise the President concerning financial matters. The committee should review annually with the officers and the external auditors the financial statement of the NBME and the external auditors's report and should report and make recommendations to the Executive Board and to the NBME.
- (2) The Treasurer should be the Chairman of the Finance Committee.

Nominating Committee

The Chairman of the Nominating Committee should be provided with information concerning the needs of the NBME for members with specific types of expertise and with guidelines concerning the process to be employed in eliciting suggestions for new members.

Examination Committees

- (1) Each NBME examination committee should include the chairmen of the test committees related to that examination and should meet prior to each examination of the NBME in order to review each examination.
- (2) There should be at least one meeting each year of the above NBME examination committees for the purpose of discussing policy issues relevant to the examinations of the NBME.
- (3) A chairman of this group should be elected by the group and would serve as an ex officio member of the NBME with vote.

Test Committees

Test committees representing the major categories of the basic and clinical sciences to be addressed in NBME examinations as determined by the NBME should be appointed by the President after suggestions for membership have been obtained from appropriate sources. The President should appoint members in such numbers and for such terms of office as may be designated by the Executive Board. The Chairman of each test committee should be appointed by the President with advice from appropriate members of the NBME staff. The test committees should be charged by the President with the objectives of the NBME and of the purposes to be accomplished by the construction of examinations of the NBME.

The test committees should be responsible for the creation of test material in their respective fields that addresses the objectives of the examinations. The staff of the NBME should be responsible for advising test committees in their determination of the format and content to assure that they are in accord with objectives of the examinations and the goals of the NBME.

D) OFFICERS

It became apparent during several discussions that there was a need to clarify the responsibilities and authorities of officers of the NBME. No change appeared to be necessary in the defined responsibilities of the Chairman and Vice Chairman.

It was noted that the President is the individual accountable to the Executive Board and the NBME for implementing and carrying out policies designed by the Executive Board and the NBME and that other senior salaried staff officers are responsible and accountable to the President. In accordance with this principle, it was determined that other senior staff members, Vice Presidents, and Secretary should be elected by the Executive Board upon nomination of the President. While staff officers should be expected to attend and participate actively in discussions conducted by the Executive Board and the NBME, only the President, in accord with both the academic model as well as other service organizations, should be a member of the governing body.

The President

The President should be the salaried Chief Executive Officer of the NBME, should be appointed by the Executive Board, _____ and the Board* should be accountable to the Executive Board, /should be an ex officio member of the NBME and the Executive Board with voting privileges, and should have the responsibility and authority for: a) implementing all policies of the NBME; b) directing and assuming the responsibility for the quality and conduct of all activities, programs, and services provided by the staff; c) hiring, firing, and directing all salaried personnel; d) delegating responsibility and authority to other salaried personnel as appropriate; and e) exercising such other authority and responsibility that the Executive Board considers pertinent to the office.

The Vice President(s)

- (1) Vice President(s) should be salaried officers of the NBME, should be nominated by the President, elected by the Executive Board, should be accountable to the President, and should discharge such duties as the President considers pertinent to this office.
- (2) Vice President(s) should attend and participate actively in meetings of the NBME and the Executive Board.

The Treasurer

The Treasurer should be an elected officer and serve as the Chairman of the Finance Committee, and a) review the fiscal policies and procedures of the NBME; b) review as often as is deemed necessary the NBME's operating and capital budgets and

*floor amendment

management of invested funds; c) report to the NBME annually and to the Executive Board at each regular meeting the financial status of the NBME with such recommendations as the Treasurer and/or the Finance Committee consider indicated.

The Secretary

- (1) The Secretary should be a salaried officer of the NBME, should be nominated by the President, elected by the Executive Board, should be accountable to the President, and should discharge such duties as the President considers pertinent to this office.
- (2) The Secretary should attend all meetings of the NBME and the Executive Board.

E) MEETINGS

The effectiveness of the NBME depends in a realistic way upon maintaining communications with the many organizations it relates to and especially the client organizations. Because Annual Meetings frequently are devoted to discussions of policy matters, changes occurring within the NBME, or innovations in the process of development or implementation, it is desirable that representatives of client organizations have the opportunity to participate in those discussions.

Meetings

By invitation, annual meetings of the NBME may be open to designated representatives of client organizations. Such invitees should be permitted the privilege of the floor without vote and should be expected to pay their own expenses.

F) RELATIONSHIP OF THE NBME TO OTHER ORGANIZATIONS

The NBME has become progressively more aware of the need for its staff members, especially officers, to avoid any conflict of interest through their participation in policy-making decisions of other organizations that relate to the NBME and especially those that utilize the services of the NBME.

Relationship of NBME to Other Organizations

In order to avoid conflicts of interest between the NBME and other organizations whose policies or professional activities relate to or involve the NBME, officers and staff members of the NBME should not be designated as formal representatives of the NBME to such organizations with the privilege of holding office or voting on policy matters in such organizations. This should not preclude the participation of officers and staff members of the NBME on behalf of the NBME in the activities of such organizations as consultants or non-voting members.

Eliminated by action of the Board.

II. Implementation of the Comprehensive Qualifying Examination

In 1973 the National Board of Medical Examiners accepted the Report of the Goals and Priorities Committee and assigned to the Executive Committee of the Board the authority over priorities in its implementation. The Goals and Priorities Committee Report recommended that an examination be developed by the National Board for the purpose of evaluating the ability of graduating medical students to assume limited responsibility for patient care under supervision in graduate medical education. Subsequent to the action by the Board, the Executive Committee established a committee on undergraduate evaluation which was charged to oversee the development of a comprehensive qualifying exam.

In 1975 the AAMC endorsed the concept of a comprehensive qualifying exam (see page 84), but stated that the three part examination system of the National Board of Medical Examiners should not be abandoned until a suitable examination had been developed to take its place and had been assessed for its usefulness in examining medical students and graduates in both basic and clinical science aspects of medical education.

In 1977 the responsibility for the CQE development was removed from the advisory committee for undergraduate evaluation and invested in a new group called the CQE Coordinating Committee. At the March 1980 meeting, a prototype examination was presented for discussion and action by the Board.

The prototype examination is made up of 671 test items distributed in the categories as shown in Figure 1 on page 82. About 80% of the items are drawn from existing questions from the Part I, II, and III examinations. There are about 140 experimental problem solving items. The development of a unique new type of item to relate basic and clinical sciences has not moved as rapidly as expected and will be placed in the examination at a later date. The distribution of test items by discipline is shown in Figure 2.

The proposed schedule for development of the examination and its field testing are shown in Figure 1. The planned rate of implementation after the field tests this spring is not clear, but an implementation workshop is tentatively scheduled for the spring of 1981.

The major concern about the evolution of the CQE is whether the Board is sensitive to the AAMC's 1975 concern that the examination be assessed for its usefulness in examining medical school students and graduates in both basic and clinical science aspects of medicine, and whether the Board plans to involve the academic community in that assessment. Carmine Clemente, at the March meeting, eloquently expressed his concern about the possibility of a strong reaction from the faculties if they were not fully informed about the characteristics of the examination. He suggested that the member societies of the Council of Academic Societies be involved in the inspection of the prototype exam and the evaluation of the field test results. The Board

is keeping the prototype examination under security and is reluctant to develop a prototype which can be broadly disseminated.

FIGURE 1

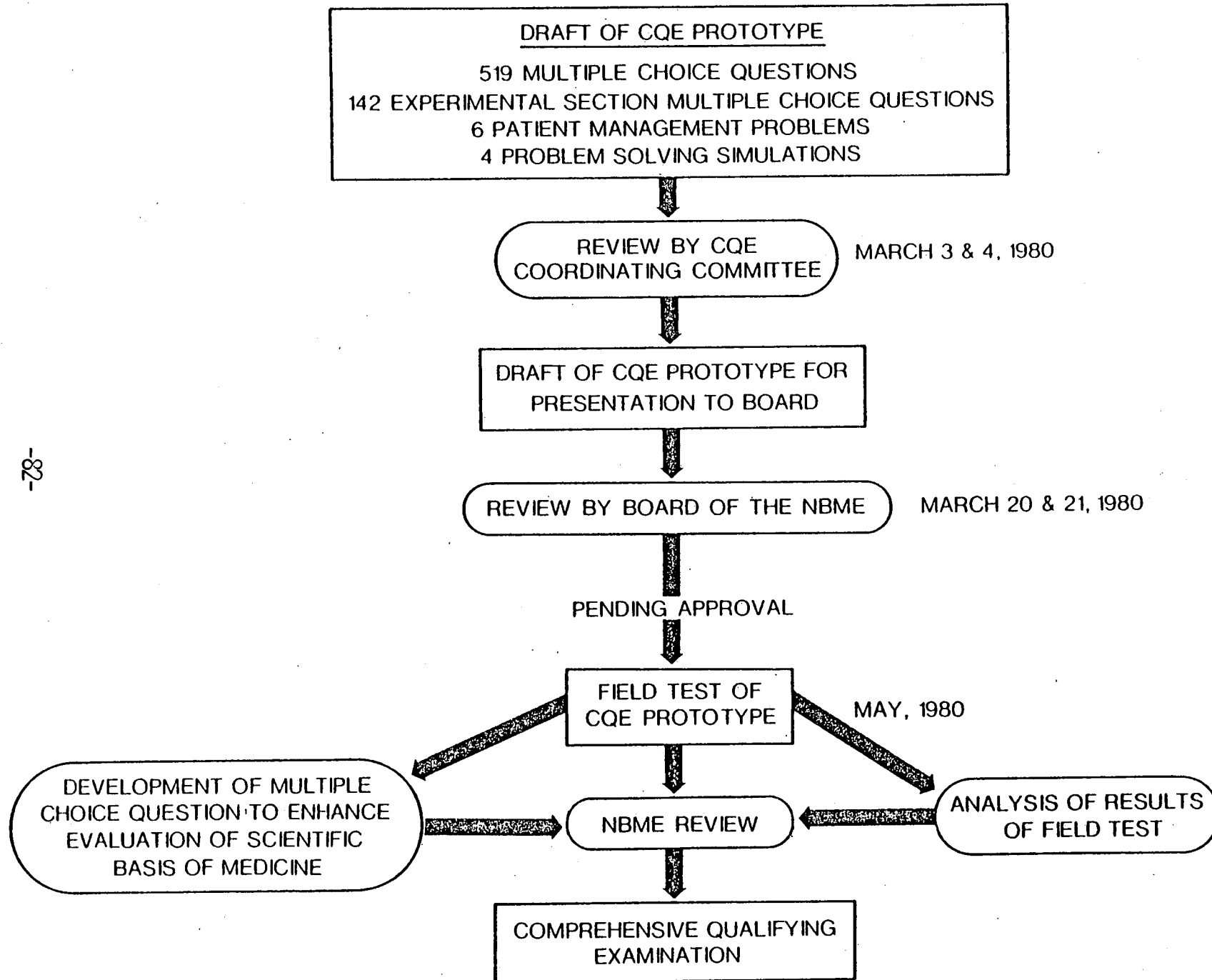
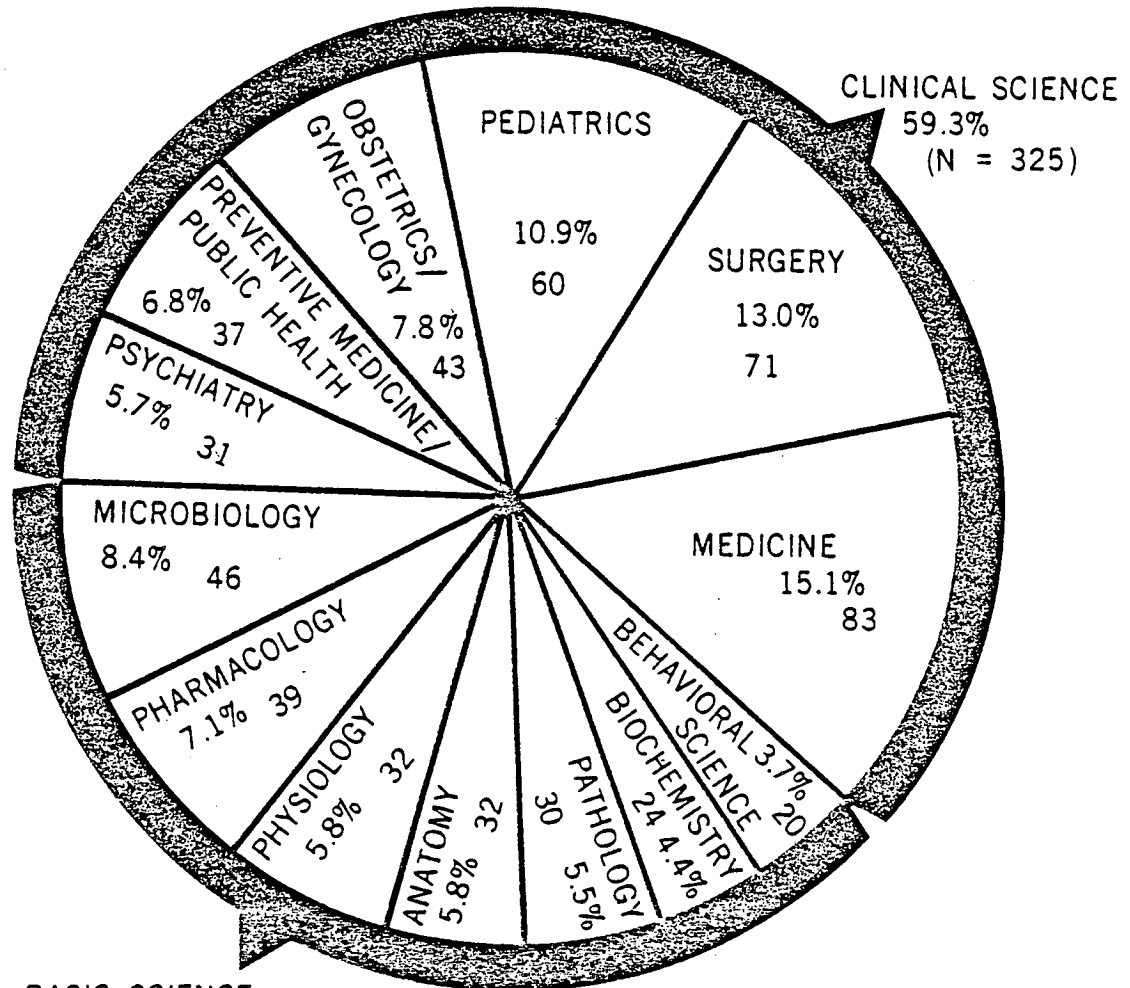


FIGURE 2

CQE PROTOTYPE DISTRIBUTION OF MULTIPLE CHOICE QUESTIONS GENERAL SECTION

* (N = 548)

BY DISCIPLINE



BASIC SCIENCE
40.7%
(N = 223)

* INCLUDES 44 ITEMS (ORIGINALLY DEVELOPED BY PART II OR PART III COMMITTEES) THAT ADDRESS BASIC SCIENCE PRINCIPLES AND THEREFORE ARE COUNTED IN BOTH THE APPROPRIATE BASIC AND CLINICAL SCIENCE DISCIPLINE

Installation of the Chairman

Dr. Mellinkoff presented the gavel to Dr. Leonard W. Cronkhite, Jr., the new AAMC chairman. In accepting, Dr. Cronkhite expressed the Association's appreciation and thanks for Dr. Mellinkoff's dedicated leadership and sense of humor during his year as chairman.

Adjournment

The Assembly was adjourned at 4:05 p.m.

Addendum

**Response of the AAMC
to the Principal Recommendations
of the Goals and Priorities
Committee Report to the National
Board of Medical Examiners**

The Association of American Medical Colleges has long been engaged in furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals, and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This is a response to the National Board of Medical Examiners' Goals and Priorities (GAP) Committee report entitled, "Evaluation in the Continuum of Medical Education."

The responses recommended in this document are a consensus derived from a task force report which provided the basis for extensive discussion and debate by the Councils, the Organization of Student Representatives, and the Group on Medical Education. The consensus was achieved through deliberation by the Executive Council and is now presented to the Assembly for ratification.

On the assumption that the report of the Goals and Priorities Committee, "Evaluation in the Continuum of Medical Education," has been widely read, an extensive review and analysis is not provided here. The report recommends that the NBME reorder its

examination system. It advises that the board should abandon its traditional three-part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam "Qualifying A," and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as "Qualifying B." This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: (a) assist individual medical schools in improving their capabilities for intramural assessment of their students; (b) develop methods for evaluating continuing competence of practicing physicians; and, (c) develop evaluation procedures to assess the competence of "new health practitioners."

Responses

1. The AAMC believes that the three-part examination system of the National Board of Medical Examiners should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school students and graduates in both the basic and clinical science aspects of medical education.

2. The AAMC recommends that the National Board of Medical Examiners should continue to make available examination materials in the disciplines of medicine now covered in Parts I and II of the National Board exams, and further recommends that faculties be encouraged to use these materials as aids in the evaluation of curricula and instructional programs as well as in the evaluation of student achievement.

3. The AAMC favors the formation of a qualifying exam, the passing of which will be a necessary, but not necessarily sufficient, qualification for entrance into graduate medical education programs.

Passage of Parts I and II of the National Board examination should be accepted as an equivalent qualification.

The following recommendations pertain to the characteristics and the utilization of the proposed qualifying exam: (a) The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed. (b) The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas. (c) The exam should be criterion-referenced rather than norm-referenced. (d) Test results should be reported to the students taking the exam, to the graduate programs designated by such students, and to the schools providing undergraduate medical education for such students. Item analyses and other aggregate data should be made available to institutions desiring to assess their curricula and educational programs. (e) The exam should be administered early enough in the students' final year that the results can be transmitted to the program directors without interference with the National Intern and Resident Matching Program. (f) Students failing the exam should be responsible for seeking additional education and study, and medical schools should be encouraged to provide the additional academic assistance if students so request. (g) Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs

of graduate medical education in the United States.

4. The AAMC doubts that medical licensure bodies in all jurisdictions will establish a category of licensure limited to practice in a supervised education setting. Therefore, the AAMC recommends that the Liaison Committee on Graduate Medical Education should require that all students entering accredited graduate medical education programs pass the qualifying exam. The LCGME is viewed as the appropriate agency to implement the requirement for such an exam.

5. The AAMC should assume leadership in assisting schools to develop more effective student evaluation methodologies and recommends that the Liaison Committee on Medical Education place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.

6. The AAMC recommends that the LCGME and its parent bodies take leadership in assisting graduate faculties to develop sound methods for evaluating their residents, that each such faculty assume responsibility for periodic evaluation of its residents, and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are ready to be candidates for board exams.

7. The AAMC recommends that physicians should be eligible for full licensure only after the satisfactory completion of the core portion of a graduate medical educational program.

III. The Relationship Between the Comprehensive Qualifying Examination and the Proposed Federation Licensing Examination I (FLEX I)

At the 1979 Spring meeting of the Council of Deans, Bryant Galusha, M.D. reported on the plans of the Federation of State Medical Boards to develop a two part licensing program consisting of a preliminary limited license to practice in a supervised educational setting based on passing an examination (FLEX I) and a full license after two years of graduate medical education based on passing a second examination (FLEX II).

The development of this program derives to a significant degree from the NBME's GAP Report and, in presentations to the National Board and to other organizations, both the officers of the NBME have indicated that the FLEX I examination will most likely be the CQE.

However, it is apparent that the Federation considers its new FLEX I - FLEX II program to belong to the Federation and it presumably plans to maintain its authority to determine the content, weighting, and scoring policies as it does with the current FLEX exam. The FLEX examination is developed by the Federation through a contract with the NBME. Its test committees select test items from the National Board pool, determines their distribution between basic and clinical sciences, and establishes the weighting of sections of the examination in determining the final score. The NBME's role is to supply test items and provide technical assistance under contract. The Federation collects the examination fee and reimburses the National Board for its obligations under contract. The Federation generates income from its FLEX testing program. In an address presented at the 75th Congress on Medical Education in 1975, Dr. Galusha stated, "I will confess that the committee is cognizant of the fact that the Federation may face financial woes as a result of the decreasing number of foreign medical graduates being available to take the present FLEX exam (presently the largest number of FLEX candidates are foreign medical graduates and revenue from the FLEX exam is the major source of income for the Federation). It is not true that the committee is recommending the FLEX I - FLEX II concept for assuring the financial solvency of the Federation. Clearly, the major reason for the committee's recommendations of FLEX I - FLEX II is the promise it holds in improving the quality, uniformity, and accountability of the licensing process". Later in his address, Dr. Galusha stated, "--adoption of the FLEX I - FLEX II concept using the National Board of Medical Examiners' Comprehensive Qualifying Examination as FLEX I would result in a progressive phasing out of the National Board of Medical Examiners certification program. At that time, National Board involvement in examinations for medical licensure in the United States would be restricted to FLEX".

If the FLEX I - FLEX II program is instituted and if the relationship which presently exists between NBME and FSMB prevails, the Federation will have the final authority over the characteristics of the CQE. In the future this could mean that the FSMB could modify

the CQE to meet its own perceptions of how students should be evaluated at the interface between undergraduate and graduate medical education. Inquiries to clarify the question of whether NBME or FSMB would have final authority have been met by reassurances that the NBME would contain control, but conflicting signals have made this an open question.

The AAMC in 1975 stated that it doubted whether medical licensure boards in all jurisdictions would establish a category of limited licensure and recommended that the LCGME should be the body requiring an examination at the interface between undergraduate and graduate medical education. Presumably if the LCGME required the CQE it would not attempt to gain authority over its content and characteristics, nor would it have a financial stake in its ownership.

A PROPOSAL FOR A STUDY OF THE
GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN

Medical education in the United States has been undergoing significant evolutionary changes. These changes have been in response to the rapid expansion of biomedical knowledge and technological advances that have provided physicians with much more effective preventive diagnostic and therapeutic capability than in the past. As a consequence, the formal education of most medical students now includes a three to seven year graduate phase, and the term "undergraduate phase" is now used to designate education leading to the M.D. degree. The undergraduate phase is preparation for the graduate phase rather than for independent practice. Data from tracking studies of medical school graduates conducted by the National Residency Matching Program demonstrate that over 90% of the students who graduated in 1977 entered graduate medical education and have continued their education in a specialty.

During the undergraduate phase, students learn the body of knowledge necessary to understand the new and rapidly evolving concepts of the structure and function of living organisms and their application to an understanding of the disease. They also must acquire the basic clinical skills and professional attitudes that all physicians are expected to have. By the time of their graduation from medical school, they should have completed their general professional education and be prepared to enter their specialized graduate phase.

There is a concern in some quarters that today's graduates are not as well prepared to enter their specialized graduate phase as they should be. A required one to two year general residency that would precede entrance into a specialty program has been suggested by the Council on Medical Education of the American Medical Association. Implementation of this suggestion would inevitably lengthen the formal education of the physician.

Rather than extending general education into the graduate years, the undergraduate phase should be examined and its effectiveness in providing general professional education should be assessed.

A major assessment of the status of the undergraduate phase of medical education is particularly appropriate at this time because of other factors as well. Rapid changes have occurred in what students must learn and also in the environment of medical schools. The number of students has doubled during the past decade. The number of medical schools has increased by a fourth and the size of the faculty is one and a half times greater than that of the 1960's. Medical schools have evolved into complex organizations best described as "academic medical centers" having many missions and responsibilities. The general professional education of medical students is only one of the demands placed on these institutions and their faculties.

A national examination and discussion of the concepts and goals of education to the level of the M.D. degree will focus attention on the problems that both faculties and students

face. Solutions can be debated and the institutions can plan adaptations to improve both college preparation and medical school education.

QUESTIONS TO BE ASKED

The following are some of the factors that have had significant influence on the evolution of medical education and some of the questions that need to be addressed in an assessment of the general professional education of the physician.

The life sciences have evolved from being largely empirical and descriptive into sciences providing fundamental knowledge about the molecular and cellular basis of life processes. The expansion of knowledge in these sciences has been explosive and has provided physicians with new concepts of the structure and function of living organisms. These new concepts have in turn made the practice of medicine more scientific and less empirical. It is essential that all students, during their formal professional education, acquire an understanding of the concepts which are fundamental to their being scientific practitioners of medicine.

Education in the sciences has always been a prerequisite for admission to medical school. Faculties have almost universally required at least completion of college courses in biology, chemistry, and physics. They have admitted students who demonstrated superior achievement in these courses and have expected that those admitted will be prepared to acquire the knowledge and learn the concepts taught in biochemistry,

anatomy, physiology, microbiology, and pharmacology. The change in the knowledge base and the concepts taught in the sciences in college and the need for students to acquire new knowledge and concepts in the sciences basic to medicine raise several questions.

- Are medical school faculties aware of the changes in the content and the teaching of life sciences in college?
- Have the basic science courses in medical school been adapted to the new knowledge and concepts that students bring with them from college?
- Have medical school faculties been able to articulate the essential scientific knowledge and concepts needed for the general professional education of the physician?
- Should the college course requirements and other criteria for admission to medical school be modified?

The rapidly changing scientific basis of medicine has been paralleled by efforts to achieve a greater diversity among those admitted to medical school. Faculties have expressed the desire to admit more broadly educated students and students from different socioeconomic and ethnic backgrounds. The proportion of women in medical school has increased to 25% of the class. This has resulted in greater heterogeneity of the student body and the desirability of even greater heterogeneity

is often expressed. There is a strong view that because physicians ultimately are expected to serve the needs of all the people in our diverse society, a greater diversity in their backgrounds will better meet the public need. Such heterogeneity poses several questions.

- Can the content and sequencing of college courses in the life sciences be improved to allow students pursuing a variety of different majors to acquire the scientific education needed for medical school?
- Can medical school faculties adapt their programs to accommodate a variety of students with different levels of scientific preparation?
- Can medical school faculties capitalize on the increasing educational and demographic diversity of their students and build upon this diversity in their general professional education?

Advances in biomedical knowledge have been accompanied by an increasing public expectation that if this knowledge is imparted to medical students, social problems--such as changing sexual mores, nutritional fadism, drug and alcohol abuse, and the dependency of an aging population--will be solved. Special interest groups concerned with these and other problems are attempting to manipulate medical school curricula through state and federal government initiatives. Considering the limitation of time and intellectual resources available to both students and faculties and the diverse

careers and roles that physicians ultimately assume in practice, the degree of emphasis and the timing of the introduction of special interest areas into the general professional education of the physician must be carefully examined. Faculties must decide the following:

- Can they respond to myriad special interest groups and maintain the essential programs for the general professional education of all physicians?
- What should be the timing and approaches to introducing special subject areas for which there is substantial merit and need?

During their undergraduate education all students must acquire basic clinical skills, develop clinical judgment, and adopt professional attitudes. Providing a sound general professional education also requires that their basic science knowledge be integrated with their clinical education. Responding to the advancing knowledge and technology of medicine, teaching hospitals have adapted to the increasingly specialized care that must be provided. Accordingly, general medical and surgical services are less common in teaching hospitals and units for specialized care are becoming more common. Clinical faculties have also become more and more specialized. These changes, which have accommodated the patient care and research responsibilities of teaching hospitals and their faculties, have made the environment in which medical students are expected to learn basic clinical skills much more complex than it was a generation ago. It is becoming difficult to provide basic

clerkships in which students can observe and study both hospitalized and ambulatory patients under the guidance of skilled clinical teachers who have both the breadth and depth needed to integrate teaching basic clinical skills and judgment with the basic sciences. In this context, several questions emerge.

- Are the basic clerkships for students meeting their needs for general professional education?
- Is the performance of students in the clinical setting sufficiently well evaluated to ensure that all graduates have acquired basic skills and appropriate professional attitudes?
- Can the integration of clinical education and the basic sciences be improved?

Medical licensure policies are being directed increasingly toward setting a national standard for initial licensure and requiring evidence of participation in continuing education to maintain licensure. At least 50 medical schools require students to pass Parts I and II of the National Board of Medical Examiners' licensure sequence to be promoted and graduated. The Federation of State Medical Boards has recently recommended a policy that each state require preliminary licensure based on a national examination before students can enter the graduate phase of their education. These proposals raise several questions.

- Is the development of a national licensure examination a step toward a national curriculum

that might stifle attempts by medical school faculties to develop educational programs that reflect their institutions' special missions and unique resources?

- Is the introduction of a licensure examination at the interface between undergraduate and graduate medical education appropriate?
- Are medical students being taught that they have a personal responsibility to develop and maintain proficiency and are they acquiring the skills to do so?

THE APPROACH

Accomplishing an assessment of the current status of the general education of the physician and possible approaches to its improvement is a complex task. Data on the names and types of courses taught and the number of hours or weeks required would be of very limited value. The central question is, what knowledge and concepts should students learn, what basic skills should they acquire, and what attitudes should they develop as they progress through college and medical school? The broad engagement of the faculties is needed if improvements are to occur. The project must stimulate free ranging discussion among faculties, both within their institutions and within their disciplines. To accomplish this, the following strategy is proposed.

A panel of 11 members will be selected and appointed by

the AAMC Executive Council. Individuals will be chosen who have significant experience and interest in medical education and who have made recognized contributions to their own discipline or area. A willingness to commit significant time to the project will be a key selection factor. The panel will consist of

- 2 medical school deans
- 2 basic science faculty members
- 2 clinical science faculty members
- 1 teaching hospital chief executive officer
- 1 liberal arts faculty member
- 1 natural science faculty member
- 1 resident
- 1 public member

The panel will develop its agenda and areas of emphasis utilizing the following strategy for the involvement of the AAMC constituency and others concerned with the general education of physicians.

A. Involvement of the Medical Schools

Medical school deans and their senior administration staffs will be asked to contribute their views of the current status, problems and opportunities in the general education of physicians through a survey. They will be asked to focus particularly on academic organization, curriculum structure, approaches to teaching, and approaches to evaluation. Based on the responses, the panel will invite selected schools and

individuals to appear before it.

The institutional viewpoint will also be sought by asking members of the AAMC's Group on Student Affairs and Group on Medical Education to appear before the panel. These groups are composed of associate or assistant deans for student affairs, admissions, academic affairs, curriculum, continuing medical education, graduate medical education, and research in medical education. The groups hold both regional and national meetings and provide a forum for the discussion of educational issues by those with day-to-day operational responsibilities.

Students views will be obtained through asking the Association's Organization of Student Representatives to stimulate discussion and solicit ideas from the student representatives of the 112 schools that participate in this organization.

B. Involvement of the Disciplines

Selected member societies of the AAMC's Council of Academic Societies will be asked to prepare written presentations on the views of their membership on the current status, problems, and unfulfilled opportunities in the general education of physicians. They will be expected to focus particularly on vital knowledge and

concepts essential to their discipline or area of interest. They will be strictly reminded of students' limitations of time and intellectual and physical energy. Representatives from selected societies will be asked to "testify" before the panel and debate the views which are presented.

The CAS has 70 member societies. Examples of those that might be invited to participate are:

Association of Anatomy Chairmen

Association for the Behavioral Sciences
and Medical Education

Association of Medical School Departments
of Biochemistry

Society for Neuroscience

Association for Medical School Pharmacology

Association of Teachers of Preventive Medicine

Association of Pathology Chairmen, Inc.

Association of Professors of Dermatology, Inc.

Society of Teachers of Family Medicine

Association of Professors of Medicine

Association of University Professors of
Neurology

Association of Medical School Pediatric
Department Chairmen, Inc.

Association of Academic Physiologists

American Association of Chairmen of Depart-
ments of Psychiatry

Association of Professors of Gynecology
and Obstetrics

Society of Surgical Chairmen

American Association of Neurological Surgeons

Association of University Professors of
Ophthalmology

Association of Orthopaedic Chairmen

Association of Academic Departments of
Otolaryngology

Educational Foundation of the American Society
of Plastic and Reconstructive Surgeons, Inc.

Society of University Urologists

Society of Academic Anesthesia Chairmen, Inc.

Society of Chairmen of Academic Radiology
Departments

American Federation for Clinical Research

Society for Pediatric Research

Other national organizations with an interest in medical education will be invited to submit their views to the panel as well. Examples of such organizations are the Council of Medical Specialty Societies, the American Medical Association, and the American Board of Medical Specialties.

C. Involvement of Undergraduate Colleges

Undergraduate colleges that provide a significant number of medical school matriculants will be solicited regarding their faculties' views. After reviewing their responses, selected individuals will be asked to appear before the panel.

Following the preliminary organizational and agenda development meetings in Washington, D.C., the panel will hold

meetings at selected medical schools (and perhaps undergraduate colleges) around the country. These will be chosen to provide both a mix of institutions and geographic coverage. The meetings will be open and well publicized. Faculty, students, and staff from the host institutions and from those in the region will be invited to attend, and ample time will be provided to permit comment. It is estimated that about 10 meetings of the panel will be held in the field and two to four in Washington, D.C.

As the work of the panel proceeds, individuals will be identified to contribute formal papers for editing and inclusion in the panel report.

It is estimated that the project will require 30 to 36 months. The success of the project will depend upon the quality of the panel and staff and upon stimulating a high level of interest in the medical schools, academic societies, undergraduate colleges, and others asked to contribute their views and ideas. It is not possible to predict the depth and scope of the study at this time, but the expected outcome is a report on the status of the general education of physicians with recommendations for modifications and improvements.

STAFF AND RESOURCES AVAILABLE

The project will be directed by August G. Swanson, M.D., Director of Department of Academic Affairs. There will be a core staff devoted exclusively to the project. It will consist of a senior staff associate assigned to be the coordinator-

editor and a staff associate to assist in the development of background papers and the evaluation of position papers submitted by participating constituents. In addition, a search will be made for a current faculty member who has experience and talent who would be interested in taking leave and joining the project for one to two years as a special staff consultant. A full-time secretary and staff assistant will be required to serve the core staff.

Full-time staff of the Association who will also contribute to the work of the project will be from the following units:

1. The Department of Academic Affairs, its Division of Educational Measurement and Research, and its Division of Student Programs including the Office of Minority Affairs;
2. The Department of Institutional Development, and its Divisions of Accreditation and Institutional Studies;
3. The Department of Teaching Hospitals;
4. The Department of Health Services;
5. The Division of Educational Resources; and
6. The Division of Operational Studies

Within these departments and divisions are individuals with significant experience and knowledge about medical education and the medical schools. Utilizing their knowledge and talent, studies can be undertaken in support of the panel's needs for

information. Through the Association's computerized data banks, information about the characteristics of the institutions, their faculties, and students is available.

The Division of Educational Measurement and Research is engaged in two relevant projects which will assist the study. First, studies of the validity of the revised Medical College Admission Test, introduced in 1977, are being developed. The revised MCAT is designed to test students' achievement in biology, chemistry, and physics with very narrow specifications to confine the content to material taught in introductory courses. Second, the division has been engaged for two years in a study of the evaluation of students' performance in the clinical setting. Over 500 faculty members responsible for the evaluation of third year students have been involved in the study. These contacts and the information already gained about approaches to the evaluation of students in internal medicine, surgery, psychiatry, obstetrics and gynecology, pediatrics, and family medicine will be a valuable resource.

The Council of Deans, the Council of Academic Societies, the Council of Teaching Hospitals, the Organization of Student Representatives, the Group on Student Affairs, and the Group on Medical Education provide access to the medical education community. The Association also has close relationships with other national organizations concerned with all aspects of the education of physicians, and its experienced staff make it the logical organization to undertake this project at this time.

INVITATIONAL MEETING ON
GRADUATE MEDICAL EDUCATION TASK FORCE REPORT

The membership of the Task Force on Graduate Medical Education and its working groups consisted of many individuals who play key roles in national organizations and agencies concerned with graduate medical education. However, these members were selected as individuals and were not expected to represent their organization or agency. By this mechanism and through the discussion of a draft of the report at the Special Assembly meeting in November 1979, the scope and thrust of the report is widely known.

From its inception, the goal of the Task Force has been to create a report that will stimulate discussion and promote improvement in graduate education. The report should be viewed as the basis for beginning discussions rather than a firm set of recommendations and positions handed down by the AAMC. In order to facilitate active involvement in the consideration of the report by other important organizations and agencies involved in graduate medical education, a proposal that the AAMC sponsor an invitational conference was approved by the Executive Council in January.

The conference will be held in Washington D.C. on September 29-30. The report and invitations were recently sent to participating organizations. Each organization was encouraged to send written comments in advance for inclusion in an agenda book. Representation from each invited organization will be limited to one or two persons. Consideration will be given to a summary report of the meeting which might include the comments received in advance.

Each organization will be expected to pay for the travel and accommodation of its members. The Association's expenditures will be limited to the rental of meeting rooms, two lunches and one dinner (approximately \$18,000) and printing, mailing and staff time.

The conference will be organized to provide opportunities for discussions of each chapter in groups of 20-30, and summary discussions in plenary sessions. The purpose of the conference is to stimulate all who are involved with graduate medical education to expand upon the proposals set forth in the Report and to identify how improvements in graduate medical education can be accomplished.

INVITATION LIST

<u>Group</u>	<u>No. Invites</u>
1. Specialty Boards	24
2. Specialty Colleges	24
3. RRC Chairmen	23
4. CAS - Presidents - Clinical Organizations	22
5. LCGME	26
6. Institute of Medicine	1
7. Association of Academic Health Centers	2
8. Association for Hospital Medical Education	2
9. American Medical Student Association	2
10. National Medical Association	2
11. National Medical Student Association	2
12. Health Insurance	2
Blue Cross/Blue Shield	(1)
Health Insurance Association of America	(1)
13. Federation of State Medical Boards	2
14. National Board of Medical Examiners	2
15. Foundations	7
Kellogg Foundation	(1)
Henry J. Kaiser Family Foundation	(1)
Educational Foundation of America	(1)
Commonwealth Fund	(1)
Robert Wood Johnson Foundation	(1)
Macy Foundation	(1)
National Fund for Medical Education	(1)
16. American Association of Dental Schools	1
17. American Osteopathic Association	1
18. Task Force	22
A. Members	(12)
B. Chairman and Working Group Chairmen	(6)
C. Observer Participants	(2)
D. Special Staff Consultants	(2)

<u>Group</u>	<u>No. Invites</u>
19. Chairmen, AAMC Assembly, COD, CAS, COTH	4
20. Conference Speakers	6
21. Congressional Staff	7
22. Federal Agencies	10
A. Health Resources Administration	(2)
B. Health Services Administration	(2)
C. Health Care Financing Administration	(2)
D. Veterans Administration	(2)
E. HEW Secretariat	(1)
F. GMENAC	(1)
23. Group Health Association of America (HMO Representative)	1
24. Residents	2
25. Individuals	1

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<i>University of South Alabama</i>	<i>Clyde G. Huggins</i>	
ARIZONA		
<i>University of Arizona</i>	<i>Louis J. Kettel</i>	
ARKANSAS		
<i>University of Arkansas</i>	<i>Thomas A. Bruce</i>	
CALIFORNIA		
<i>University of California - Davis</i>	<i>Ernest M. Gold</i>	
<i>University of California - Irvine</i>	<i>Stanley van den Noort</i>	
<i>University of California - L.A.</i>	<i>Sherman M. Mellinkoff</i>	
<i>University of California - San Diego</i>	<i>Marvin R. Dunn</i>	
<i>University of California - San Fran.</i>	<i>Julius R. Krevans</i>	
<i>Loma Linda University</i>	<i>G. Gordon Hadley</i>	

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<i>Stanford University</i>	<i>Lawrence G. Crowley</i>	
COLORADO		
<i>University of Colorado</i>	<i>M. Roy Schwarz</i>	
CONNECTICUT		
<i>University of Connecticut</i>	<i>Robert U. Massey</i>	
<i>Yale University</i>	<i>Robert W. Berliner</i>	
DISTRICT OF COLUMBIA		
<i>Georgetown University</i>	<i>John B. Henry</i>	
<i>George Washington University</i>	<i>Ronald P. Kaufman</i>	
<i>Howard University</i>	<i>Russell Miller</i>	
FLORIDA		
<i>University of Florida</i>	<i>William B. Deal</i>	
<i>University of Miami</i>	<i>Emanuel M. Papper</i>	

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<i>Medical College of Georgia</i>	<i>Fairfield Goodale</i>	
<i>Morehouse College</i>	<i>Louis W. Sullivan</i>	
HAWAII		
<i>University of Hawaii</i>	<i>John S. Wellington</i>	
ILLINOIS		
<i>Chicago Medical School</i>	<i>Marshall A. Falk</i>	
<i>Loyola University</i>	<i>Clarence N. Peiss</i>	
<i>Northwestern University</i>	<i>James E. Eckenhoff</i>	
<i>Rush Medical College</i>	<i>Robert S. Blacklow</i>	
<i>Southern Illinois University</i>	<i>Richard H. Moy</i>	
<i>University of Chicago</i>	<i>Robert B. Uretz</i>	

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KENTUCKY		
<i>University of Kentucky</i>	<i>D. Kay Clawson</i>	
<i>University of Louisville</i>	<i>Arthur H. Keeney</i>	
LOUISIANA		
<i>Louisiana State - New Orleans</i>	<i>Paul F. Larson</i>	
<i>Louisiana State - Shreveport</i>	<i>Ike Muslow</i>	
<i>Tulane University</i>	<i>James T. Hamlin III</i>	

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<i>Boston University</i>	<i>John I. Sandson</i>	
<i>Harvard Medical School</i>	<i>Daniel C. Tosteson</i>	
<i>University of Massachusetts</i>	<i>Robert E. Tranquada</i>	
<i>Tufts University</i>	<i>Murray R. Blair</i>	
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<i>Michigan State University</i>	<i>W. Donald Weston</i>	
<i>University of Michigan</i>	<i>John A. Gronvall</i>	
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MISSOURI		
<i>University of Missouri - Columbia</i>	<i>Charles C. Lobeck</i>	
<i>University of Missouri - Kansas City</i>	<i>Harry S. Jonas</i>	
<i>Saint Louis University</i>	<i>David R. Challoner</i>	
<i>Washington University</i>	<i>M. Kenton King</i>	
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<i>University of Nebraska</i>	<i>Alastair M. Connell</i>	

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NEW JERSEY		
<i>CMDNJ - New Jersey Medical School</i>	<i>Vincent Lanzoni</i>	
<i>CMDNJ - Rutgers Medical School</i>	<i>Richard C. Reynolds</i>	
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<i>University of New Mexico</i>	<i>Leonard M. Napolitano</i>	
NEW YORK		
<i>Albany Medical College</i>	<i>Robert L. Friedlander</i>	
<i>Albert Einstein Medical College</i>	<i>Ephraim Friedman</i>	
<i>Columbia University</i>	<i>Donald F. Tapley</i>	
<i>Cornell University</i>	<i>Theodore Cooper</i>	

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<i>New York University</i>	<i>Saul J. Farber</i>	
<i>University of Rochester</i>	<i>Frank E. Young</i>	
<i>SUNY - Buffalo</i>	<i>John P. Naughton</i>	
<i>SUNY - Downstate - Brooklyn</i>	<i>Stanley L. Lee</i>	
<i>SUNY - Stony Brook</i>	<i>Marvin Kushner</i>	
<i>SUNY - Upstate - Syracuse</i>	<i>George F. Reed</i>	
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<i>Medical College of Ohio - Toledo</i>	<i>John P. Kempf</i>	
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<i>Pennsylvania State University</i>	<i>Harry Prystowsky</i>	
<i>University of Pennsylvania</i>	<i>Edward J. Stemmler</i>	
<i>University of Pittsburgh</i>	<i>Don Leon</i>	
<i>Temple University</i>	<i>Leo M. Henikoff</i>	
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<i>University of South Carolina</i>	<i>Roderick J. Macdonald, Jr.</i>	

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<i>Meharry Medical College</i>	<i>Ralph J. Cazort</i>	
<i>University of Tennessee</i>	<i>James C. Hunt</i>	
<i>Vanderbilt University</i>	<i>John E. Chapman</i>	
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<i>University of Texas - Dallas</i>	<i>Frederick J. Bonte</i>	
<i>University of Texas - Houston</i>	<i>Robert L. Tuttle</i>	
<i>University of Texas - San Antonio</i>	<i>Stanley E. Crawford</i>	
<i>University of Texas - Galveston</i>	<i>George T. Bryan</i>	
<i>Texas Tech University</i>	<i>George S. Tyner</i>	

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<i>University of Virginia</i>	<i>Norman J. Knorr</i>	
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<i>University of Washington</i>	<i>Robert L. Van Citters</i>	
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<i>Marshall University</i>	<i>Robert W. Coon</i>	
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<i>Catholic University</i>	<i>José N. Correa</i>	
LEBANON		
<i>American University of Beirut</i>	<i>Raja Khuri</i>	

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