1984
SPRING MEETING of the COUNCIL OF DEANS

April 1–4, 1984
Callaway Gardens

PROGRAM

Sunday, April 1st

1:00–5:00 pm, Convention Lobby

ARRIVAL & REGISTRATION

SESSION I

5:30–7:00 pm, Willow Room

WELCOME & OVERVIEW

PRESIDENT'S REPORT
John A.D. Cooper, M.D.

REFLECTIONS ON THE ADEQUACY OF HOUSE OFFICER SUPERVISION
Richard Schmidt, M.D., *President*
SUNY-Upstate Medical Center

7:00–8:30 pm, Garden Patio

RECEPTION

* * * * * *

Monday, April 2nd

SESSION II

8:30–10:30 am, Willow Room

Moderator: William T. Butler, M.D.

EXPLORING A RELATIONSHIP WITH A FOR-PROFIT HOSPITAL
Ronald P. Kaufman, M.D.
Executive Vice President & Dean
George Washington School of Medicine and Health Sciences

MEDICAL SCHOOL/TEACHING HOSPITAL RELATIONSHIPS IN A CONTEMPORARY ERA
Jerome H. Grossman, M.D., *President*
New England Medical Center

10:30–11:00 am, Willow Room

BREAK

SESSION III

11:00–1:00 pm, Willow Room

Moderator: Richard Janeway, M.D.

AN INDUSTRIALIST'S PERSPECTIVE ON MEDICAL CARE COST CONTAINMENT
J. Paul Sticht, M.D., *Chairman*
R.J. Reynolds Industries, Inc.

Moderator: Fairfield Goodale, M.D.

ETHICAL ISSUES IN A COMPETITIVE/PROSPECTIVE PRICING REIMBURSEMENT SYSTEM
Baruch A. Brody, Ph.D., *Director*
Center for Ethics, Medicine & Public Issues
Baylor College of Medicine

H. Tristram Engelhardt, Jr., Ph.D., M.D.
Professor
Dept. of Medicine & Community Medicine
Baylor College of Medicine

1:00 pm

UNSCHEDULED TIME

* * * * * *

Tuesday, April 3rd

SESSION IV

8:30–10:30 am, Willow Room

Moderator: Edward J. Stemmler, M.D.

EDUCATING STUDENTS IN THE CLINICAL DISCIPLINES
Sherman M. Mellinkoff, M.D., *Dean*
UCLA, School of Medicine

10:30–11:00 am, Willow Room

BREAK

SESSION V

11:00–1:00 pm, Willow Room

Moderator: Arnold L. Brown, M.D.

EDUCATING STUDENTS IN THE BASIC SCIENCE DISCIPLINES
Robert L. Hill, Ph.D., *Chairman*
Department of Biochemistry
Duke University School of Medicine

1:00 pm

UNSCHEDULED TIME

* * * * * *

Wednesday, April 4th

SESSION VI

8:30–12 noon, Willow Room

COD BUSINESS MEETING

12 Noon

ADJOURNMENT

* * * * * *

PROGRAM PLANNING COMMITTEE

Arnold L. Brown, M.D.
William T. Butler, M.D.
David C. Dale, M.D.
Fairfield Goodale, M.D.
Leo M. Henikoff, M.D.
Richard Janeway, M.D.
Edward J. Stemmler, M.D.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS SPRING MEETING

Program

April 1-4, 1984
Callaway Gardens
Pine Mountain, Georgia

aamc association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

SPRING BUSINESS MEETING

SESSION I
SUNDAY, APRIL 1, 1984
5:30 P.M.-7:00 P.M.

SESSION II
WEDNESDAY, APRIL 4, 1984
8:30 A.M.-12 NOON

WILLOW ROOM
CALLAWAY GARDENS
PINE MOUNTAIN, GEORGIA

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

COUNCIL OF DEANS
SPRING BUSINESS MEETING
Willow Room
Callaway Gardens
Pine Mountain, Georgia

AGENDA

Reference--Council of Deans Membership Roster

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
ANNUAL BUSINESS MEETING

MONDAY, NOVEMBER 7, 1983
2:00 PM - 5:00 PM

Jefferson East
Washington Hilton Hotel
Washington, DC

Minutes

I. Call to Order

The meeting was called to order at 2:00 pm by Richard Janeway, M.D.

II. Quorum Call

Dr. Janeway announced the presence of a quorum.

III. Chairman's Report

Dr. Janeway thanked the Council for the opportunity to serve as its chairman over the past year. He then highlighted several matters addressed by the Board during the year including: The Projected Enrollment Survey; "sliding scale proposal" for the award of NIH research grants; the new Management Education Programs series; the Consensus Statement on Indirect Costs; Dr. Oliver's proposal for loan forgiveness for those physicians involved in research careers; ACCME Protocol for recognizing state medical societies as accreditors of intrastate CME sponsors; issues related to appointment of senior medical students to PGY-2 positions.

Dr. Janeway also reported that the Board had met informally with Dr. Edward Brandt, Assistant Secretary for HHS, to discuss select health care related issues. In addition, several members of the respective Boards of the Association had also met with Secretary Heckler; Dr. Janeway stated that all members in attendance were pleased with the openness of the dialogue with the Secretary.

He closed his remarks with a quip regarding the difficulty he had responding to the Harris Poll conducted in support of the GPEP project.

IV. President's Report

Dr. Cooper's message to the COD reflected on the theme of the Annual Meeting: Creativity and an environment which permits the gift to flourish. Dr. Cooper admonished the Deans that the times demanded a new order of leadership from those assigned the stewardship of our nation's medical schools. He differentiated creative leadership from

traditional administration and defined it as "the capacity to bring vision to the problems facing our institutions and to mobilize the commitments of others to bring that vision into reality."

V. Consideration of the Minutes

The minutes of the April 6 and April 9, 1983 Spring Business Meetings held at the Cottonwoods, Scottsdale, Arizona were approved as submitted.

VI. Report of the Nominating Committee and Election of Officers

On recommendation of its nominating committee, the Council elected Arnold Brown, Jr., M.D., University of Wisconsin Medical School as its Chairman-elect; and William Butler, M.D., Baylor College of Medicine, D. Kay Clawson, M.D., University of Kansas, and Robert Daniels, M.D., University of Cincinnati, as members-at-large.

In a subsequent action, the Council endorsed the recommendation of its nominating committee that the Assembly elect Richard Janeway, M.D., Bowman Gray School of Medicine of Wake Forest University, as Chairman-elect of the Assembly and John Naughton, M.D., SUNY at Buffalo, and Richard Moy, M.D., Southern Illinois University School of Medicine, as COD Representatives to the Executive Council.

VII. Discussion Items

A. Legislative Update

Dr. Kennedy introduced his remarks by stating that prominently displayed on John Sherman's desk was an excerpt from an 1866 New York Surrogate Court decision, which reads:

> "No man's life, liberty or property are safe while the legislature is in session."

After suggesting that much of what followed would be superceded by the time of Congressional adjournment, only eleven days away, he provided an update on:

- o The regular HHS appropriations--generally favorable;
- o The NIH renewal bills--logjammed, in part by the Madigan/Broyhill/Shelby substitute amendment;
- o Animal Legislation--both House and Senate NIH renewal bills contain a mandate for a comprehensive study by NAS;
- o Tax issues--IRS has recently capitulated on NRSA's and agreed that they qualified as scholarship for tax purposes;
- o A bill to regulate the use of tax exempt bonds would impose a state by state cap on volume; 501 C(3) organization would be exempt from the cap to fund capital improvements, but not to finance student loans;

- o A house bill limits the use of tuition as a tax exempt fringe benefit to undergraduate education and only if broadly available;

- o A House committee amendment will probably be introduced to freeze Medicare based physician fees and to require physicians to accept assignment on hospitalized Medicare patients.

Loan Consolidation - The Student Loan Marketing Association (Sallie Mae) authority to consolidate and extend student loans expired the previous week.

Chiropractic - The Senate passed, but the House did not, authorization for the payment of chiropractic services rendered veterans.

The Social Security Advisory Committee recommended that a study be conducted to find alternatives to the present system of recognizing costs of Graduate Medical Education as allowable for Medicare reimbursement purposes.

Health Planning was likely to continue under authority of continuing resolution if current negotiations aimed toward an adoptable bill failed.

Baby Doe--few legislators appear willing to oppose legislation very close to the original, now outlawed HHS regulations. The AAMC and others are pushing for a voluntary, advisory committee review approach.

B. Principles for Support of Biomedical Research

The Council endorsed the proposal that the document receive broad distribution, including to members of Congress.

C. Physician Reservist in Medical Universities and Schools

Joseph Miller, M.D., Rear Admiral, Medical Corps, USMR-R, described the Navy's Physician Reservist Program stressing the opportunity for faculty to earn reserve credit while simultaneously providing support for the Country's military preparedness. He encouraged the Deans to communicate the opportunities to members of their faculties.

VIII. Information Items

A. Issues Related to Commercial Sponsorship of Medical Education Programs

Dr. Janeway called attention to the material in the agenda book on this subject. He reported that a recent communication to Dr. Cooper Richard S. Wilbur, Secretary of the ACCME expressed concern that several medical schools may be inappropriately co-sponsoring CME activities supported by pharmaceutical companies and/or equipment manufacturers. On behalf of the ACCME, Dr. Wilbur requested that

the AAMC Executive Council consider developing a policy statement on this matter.

Dr. Janeway reported that the COD Administrative Board had considered this issue at its September meeting and concluded that it was inappropriate for the AAMC to involve itself in the establishment of institutional policy on this matter. If there were violations of accreditation standards it should be handled as a matter between the ACCME and the institution. Because that many institutions and organizations have established internal policies to regulate the acceptance of financial support for CME programs from commercial donors, the Board recommended that information packets, which contained selected copies of such policies, be forwarded to all deans for their consideration.

B. Baby Doe

Dr. Janeway referred the deans to Dr. Cooper's correspondence, the Director of the Office of Civil Rights regarding the Association's displeasure with the HHS Proposed Rule on the Nondiscrimination on the Basis of Handicap Relating to Health Care for Handicapped Infants.

Dr. Janeway highlighted, among other concerns, HHS's proposed "alarm system" comprised of posted notices and toll free hot lines by which anonymous tipsters could summon teams of representatives from child protection agencies and/or the Office of Civil Rights to check out alledged claims of lack of treatment for handicapped infants by medical professionals.

Dr. Janeway emphasized that it was the Association's position that the proposed HHS rule should be replaced by one calling for the establishment of Infant Bioethical Review Committees (IBRCs).

C. The Organization of the National Institutes of Health, Comments by the Association of American Medical Colleges; and Testimony of Robert Berne, Ph.D. before the National Academy of Sciences Institute of Medicine Committee for the Study of the Organizational Structure of the National Institutes of Health

Dr. Janeway reported that Dr. Robert M. Berne, Chairman, Department of Physiology, University of Virginia School of Medicine testified on behalf of the AAMC, before the National Academy of Sciences, Institute of Medicine Committee for the study of the Organizational Structure of the National Institutes of Health. Dr. Berne's comments focused on a series of questions posed by the Committee: the effect of organizational changes in the last fifteen years on the flow of funds into various fields; the strengths and weaknesses of the current organizational structure of disease-based institutes, advisory councils, and peer review groups; the effect of organizational changes on the management and coordinational of biomedical research; and the effect of organizational changes on the comprehensiveness and quality of research in the affected fields.

The Association's recomendations regarding the organization of the NIH that were submitted to the Committee did contain a somewhat novel recommendation that "the NIH periodically, perhaps decennially, re-evaluate, reaffirm, revise its organizational structure through a process that involves the participation of a maximum number of interested government and nongovernment organizations."

D. Consensus from a Meeting of Faculty Members and Academic Administrators on Indirect Cost Problems

Dr. Janeway noted that the agenda book contained a letter reflecting the results of a meeting of several members of the AAU/ACE/NASULGC Joint Committee on Health Policy held in Washington in July. He emphasized, in particular, the groups resolution to urge university administrators to review efforts to present their faculties with clear explanations of the definition of indirect costs and methods for determining them; and to urge the university administrations to actively involve faculties in the development of institutional policies regarding indirect costs.

E. Recent Action on Medical Education Financing by the Advisory Council on Social Security

Dr. Janeway reported that at its August 24, 1983 meeting, the Advisory Council on Social Security adopted a resolution calling for a three-year study on medical education financing as the first step in an orderly withdrawal of Medicare funds from training support.

Dr. Janeway stated that Dr. Robert Heyssel appeared before the Advisory Committee in October to present the Association's opposition to the resolution, and stated that a comprehensive study of alternative methods for financing graduate medical education needed to be conducted and publically reported before any "orderly withdrawal" of funds was initiated.

F. AAMC Clinical Evaluation Program

The AAMC Clinical Evaluation Program, designed to assist clinical faculties in assessing students during their undergraduate and graduate clinical education was not in its implementation phase. A thirteen-member advisory group has been formed and will react to the materials and proposals generated by the program staff. Under the leadership of Xenia Tonesk, Ph.D., self-assessment materials are being developed for medical schools, clinical departments, affiliated hospitals and clinical training sites to enable them to identify strengths and weaknesses within their current evaluation systems and to determine the kinds of changes that are needed.

IX. New Business

A. GPEP Project and the Harris Poll

The members of the GPEP panel were unable to reach consensus at their recent retreat and concluded that it would be inappropriate to send a preliminary report of the Panel's Conclusion to members, in advance of the Annual Meeting. However, a summary document was prepared by the AAMC staff involved with the project, entitled Emerging Perspectives on the General Professional Education of the Physician: Problems, Priorities and Prospects. This document, which summarized the information and comments received at the four regional hearings conducted during the year, was disseminated at the Annual Meeting.

Concern was expressed regarding a Harris Poll survey that was developed in conjunction with the GPEP project and mailed to select deans, associate deans, faculty, hospital administrators, residents, students and private practice physicians around the country. The purpose of the survey was to capture the views of individuals who were not active participants in the Project thus far, but were intimately involved in the issues addressed by the Project. Several deans expressed concern that the survey format prevented respondents from stating their own views on the issues.

The following resolution was then introduced, moved, seconded and adopted by voice vote, with Dr. Tosteson dissenting: "That the Council of Deans express its view that the Harris Poll survey instrument is significantly flawed in that it prevented the expression of substantial bodies of judgement."

B. The Commonwealth Fund--Task Force on Academic Health Centers

Jerome H. Grossman, M.D., President of New England Medical Center, Inc. and Program Director of the Commonwealth Fund Task Force on Academic Health Centers announced that the Commonwealth Fund has developed a two-part program to address fundamental issues confronting academic health centers. Part I is a program of grants to encourage basic change in the provision of clinical care, medical education and biomedical research through cooperation between academic health centers and other medical institutions.

Dr. Grossman stated that the Task Force would recommend up to $1 million a year in grant awards for appropriation by the Fund's Board of Directors during the fiscal years beginning July 1983 and ending June 1986. Individual grants of up to $300,000 would be made to selected institutions on a competitive basis. The grants will provide financial support, lasting a maximum of 24 months, for the specific purpose of developing detailed plans, blueprints and implementation strategies. The plans would be executed by the chief executive officer of a teaching hospital that is a member of the Council of Teaching Hospitals of the AAMC or by the dean of an M.D.-degree-granting medical school in the U.S. accredited by the Liaison Committee on Medical Education. For further information, members were encouraged to contact Dr. Grossman at the New England Medical Center.

C. OSR Report

Ms. Pamelyn Close, OSR Chairperson, reported that OSR had begun its meeting on Friday afternoon with a business session which included remarks from Dr. Wes Clark from Senator Edward Kennedy's staff; the evening was spent with the Society of Health and Human Values in a program on ethical dilemmas of medical students. Saturday's activities also included a small group discussion with Society members and a program on acquiring teaching skills. She reported that the issues identified by OSR as most deserving of Administrative Board attention this year are: medical ethics, financial aid, housestaff concerns, teaching skills, NRMP/career decision issues, social responsibilities of physicians and curricula innovation. She noted that OSR had also formulated and approved a response to the GPEP preliminary report and expressed the hope that GPEP panel members would carefully consider it.

D. Motion of Special Appreciation

On motion, seconded and passed, the COD extended its appreciation to Dr. John Cooper for his Remarks to the Council and requested that a copy be mailed each member.

E. NLM Accepting Nominations for a New Director

William Mayer, M.D., President, Eastern Virginia Medical School, announced that the Board of Regents of the National Library of Medicine was presently accepting nominations for a new director to replace Martin Cummings. All nominations should be sent to Dr. Thomas Malone, Chairman of the Search Committee or to him as a member of the committee.

F. Appreciation

Dr. Janeway expressed thanks on behalf of the Administrative Board and the Council of Deans to William Luginbuhl, M.D. and William Deal, M.D. whose terms on the Board had expired. He presented them with engraved silver bowls as tokens of appreciation.

X. Installation of Chairman

Dr. Stemmler expressed his appreciation to Dr. Janeway for his support and management of the Council of Deans throughout the past year. Dr. Janeway was given a gavel in appreciation for his services to the Council.

Dr. Stemmler reminded the members of the Council of the Spring Meeting to be held in Callaway Gardens, Pine Mountain, Georgia on April 1-4, 1984. He also requested Council members to present ideas which they wished to be considered at the December Officer's Retreat.

XI. Adjournment

The meeting was adjourned at 4:00 pm.

D R A F T

COUNCIL OF DEANS - ISSUES IDENTIFICATION

Stimulated by the appearance of the paper, "New Challenges for the Council of Teaching Hospitals and Department of Teaching Hospitals," the Council of Deans' Administrative Board requested that the staff of the Department of Institutional Development prepare a document outlining the issues facing medical school deans and their implications for the Council of Deans as a constituent part of the AAMC, and for the AAMC itself.

What follows is an initial and very preliminary draft of such a document. It is derived in large measure from the discussion at the Council of Deans' Administrative Board Meeting held March 16, 1984.

Background

The past twenty years have been a period of remarkable growth for medical schools: a fifty percent increase in the number of institutions, a 100 percent increase in medical school enrollments, and a 300 percent growth in the number of full-time faculty. Financial support of U.S. medical schools (1960-61 through 1981-82) has grown over 500 percent, from $436 million to $2,351 million. The proportion from tuition and fees has remained constant at six percent, while state and local support has risen from 17 percent to 22 percent. The most dramatic shift has been a rise in the dependence on medical service income from six percent to over thirty percent. Federal research support has dropped from 31 to 22 percent of the medical school budgets, while other Federal support has dropped from 10 to 6 percent.

The Graduate Medical Education National Advisory Committee (GMENAC) predicted that there will be a significant surplus of physicians in the U.S. by 1990. By that year, the physician to population ratio is expected to exceed 220 per 100,000 and by the year 2000, reach 247 per 100,000. Levels in 1960 and 1978 were 141 and 171 per 100,000 respectively. While there is no universally agreed upon calculus by which need can be determined, it does appear that the large number of physicians being prepared is having an impact on the economics of medical practice and on both the geographic and specialty distribution of physicians.

Notwithstanding this dramatic growth of capacity of the U.S. for providing medical education for its citizens, ever larger numbers are enrolling in foreign schools. While we have no direct figures on foreign matriculants, several indirect measures give some assessment of the magnitude:

- the number of U.S. citizens who have graduated from foreign schools and seek certification to enter graduate medical education in the U.S. through NRMP rose from 860 in 1974 to 2,793 in 1982;
- In 1982, 1826 U.S. nationals enrolled in foreign medical schools sought advanced placement in U.S. schools (1,337 of these came from seven proprietary schools located in Mexico and the Carribean);
- It is estimated that more physicians licensed in Illinois in recent years have graduated from foreign schools than from U.S. schools;
- The 1980 GAO Report estimated a foreign school enrollment of between 8,000 and 11,000.

We have now entered a period of cost consciousness. Efforts are being made to restrain governmental outlays by regulations, encouragement of competition or straightforward budget cutbacks. Most notable, perhaps, is

the effort to constrain the growth of Medicare expenditures through prospective pricing of hospital care for Medicare beneficiaries on the basis of statistically generated norms. This shift from retrospective cost reimbursement places new management imperatives on the hospitals and their medical staffs which, in turn, may place new constraints on the ability and/or motivation of the hospital to continue historic and traditional missions related to education, research, and provision of care to the indigent. The NIH budget does not appear as robust as in times past, and programs for institutional support of medical schools and financial assistance for medical students have disappeared or are markedly diminished.

The Issues

The issues facing deans and thus, the Council of Deans, in large measure, mirror these developments; the size, cost, and quality of the enterprise are uppermost on everyone's mind. In times of plentiful resources, objectives related to effectiveness predominate; in times of scarcity, efficiency objectives gain more prominence. Thus, efficiency now appears to have gained the upper hand, but efficiency in service of trivial objectives is of no service to society nor does it contribute to the traditional missions of academic medicine. Thus, the first questions to be asked should be mission oriented; the one mission which characterizes all medical schools and academic medicine centers is undergraduate medical education.

Undergraduate Medical Education

The quality of undergraduate medical education is the subject of an entire day's discussion at the Spring Meeting; its enhancement is the

objective of the GPEP project; its preservation is the principal object of the LCME (now considering revised set of minimum standards).

Chief among the criticisms of medical education is the charge of information overload and the lack of an organized attack on the problem:

- Are we devoting sufficient attention to limiting the burden of unproductive short-term, fact memorization?
- Are we preparing students for independent learning to handle the accelerating growth knowledge from biomedical research?
- Are we developing appropriate conceptual tools and problem solving skills?
- Are we fostering high ethical standards and humanistic values?
- Is the faculty devoting adequate time to its academic responsibilities, particularly with respect to undergraduate medical students?

Recruitment and Admissions

Some observers, focusing on the decline of the applicant pool, (from a peak of 42,624 in 1974-75 to 36,730 in 1982-83), anticipate a problem of recruitment to the medical profession. They cite a number of factors:

- perceptions of a loss of status of the profession;
- difficulty in financing an education;
- concern that a physician surplus will constrain practice opportunities and limit ability to pay off sizable debts;
- fear that physician numbers will require a competitive life style, highly entrepreneurial and marketing oriented;
- observation that specialty choice may be constrained.

Questions of sociologic and economic diversity of those entering the study of medicine persist. Many minority students have experienced both

personal and financial difficulties in attempting this career and fewer students from under-represented backgrounds are considering the field viable.

Are we using appropriate criteria and asessment instruments for admission decisions?

Size

How do we best respond to perceptions that the academic medical enterprise is too large and costly?

- What are the implications of reducing class size?
- How can program reconfigurations strengthen rather than weaken institutions?
- Are faculties larger and more costly than necessary or appropriate?

Financing

What are the implications of contemporary medical school financing being so heavily dependent on income derived from professional medical services?

Are hospitals and clinical faculty members becoming too preoccupied with financial matters at the expense of academic considerations?

Are faculty practice plans organized and operated in a way which best serves the academic mission of the institution?

Organization

Is the medical center organized in a way which both permits appropriate differentiation of responsibilities for patient care, research and education and fosters adequate integration of these tasks to permit them to be accomplished effectively and efficiently?

Graduate Medical Education

Are there adequate positions available to provide appropriate graduate medical education opportunities for our graduates?

Is the process of specialty selection and GME placement sound?

Foreign Medical Graduates

Are there adequate screening mechanisms to prevent unqualified graduates of foreign medical schools from undermining the quality of medical care in this country? Of graduate medical education programs for which we are responsible?

Licensure

Does the impending replacement of the National Board of Medical Examiners Examination by FLEX I and II pose the threat of impermissible control of medical education by state licensing boards?

Quality of Care

With the current concentration on cost cutting strategies are we likely to see the adequacy of quality of medical care as a major future issue?

- Are we appropriately positioned to assess quality?
- What indicators should be developed and monitored?
- What resources should be devoted to such tasks? How directed?

Research

Aside from funding, ethical issues related to the conduct of research are among the most prominent. Are we appropriately positioned to deal with questions regarding:

- The probity of investigators?

- The treatment of human subjects of research?
- Of animal subjects?

With the prospect of increasing interconnections between industry and academic medicine, have we developed the appropriate culture, infrastructure or ethic to assure that the involvement assists rather than detracts from our ability to carry out fundamental missions?

Proprietary Hospitals

Fourteen member medical schools have affiliation (or closer) relationships with for-profit or investor owned hospitals. In at least one case (University of Louisville) such a hospital is the school's primary teaching hospital. Under current AAMC rules, these hospitals are ineligible for COTH membership. Should a mechanism be found for including such hospitals in the AAMC?

ROLE OF AAMC

With respect to each of the issues identified, the role of the AAMC needs to be assessed. Is there a role and what should it consist of? The COTH paper sets out the following framework for analysis:

"Associations of autonomous service and business entities, generally focus their activities on one or more of five goals.

Advocacy--the association works to advantage its members by obtaining favorable or avoiding unfavorable treatment from the environment in which it operates. Advocacy activties may be directed at the political process (legislative and executive) or at the private sector environment.

Economic--the association works to develop programs and member services designed to improve the efficiency and profitability of its members. Examples of such programs include group purchasing, standardized operating procedures, and multi-firm benefit and personnel programs.

Information--the association provides its members with a convenient and reliable network designed to furnish members with significant information on developments in the environment. To the extent that members are willing to share internal information with each other, the association provides a means of facilitating the exchange of "within member developments."

Education--the association develops educational programs specifically designed to meet the specialized needs of its members.

Research--the association develops an organized program to monitor the performance of its members, to develop methods or techniques which can be used by all members, and/or to identify early developments likely to affect the environment in which a member operates.

In most associations, each of these goals is present. Differences in associations seem to reflect differences in the emphasis given a particular goal and in the balance of activity across the five goals."

Governance of the AAMC and the COD

As a result of the Coggeshall Report, Planning for Medical Progress Through Education, completed in April of 1965, the AAMC was reorganized to formally involve teaching hospitals and academic societies in its governance. Thereupon, the old "deans club" was rapidly transformed into an organization with the specific objective of initiating continuous

interaction between the leadership of all components of the modern medical center. While much was achieved as a result of this transformation, there have been costs as well. Perhaps chief among these has been that the deans' sense of personal involvement with their organization has been attenuated. The 50 percent increase in the number of schools greatly added to the difficulty of the deans personally, and the AAMC as an organization in maintaining effective communications. But numbers alone were not the problem; increasing diversity added to the complexity as well. New schools consciously adopted a non-traditional approach to teaching, faculty, and relationships to hospitals. New interest groups were formed, as deans and others sought colleagueship and help from others whose situation resembled their own. Though the AAMC retained its name, and recognized the primacy of its medical school constituency by preserving a plurality of deans as voting members of the Executive Council, the sheer number of those involved in policy making for the organization has inevitably led to a diminution of the intimacy previously felt.

The diversity of interests represented and the complexity of the issues required new integrating mechanisms, more bureaucratic procedures and sometimes intricate decision making processes. The multitude of enviromental factors impinging on medical education, biomedical research and patient care, together with the rapidity with which developments occur required a full-time professional staff not otherwise occupied by responsibilities for managing institutions. Staff played an increasingly prominent role not only in coordinating the processes, but in identifying issues, analyzing their implications and proposing responses as well. On urgent matters, such as legislative developments requiring rapid response, the process often directly engaged only the Council's officers, some of the

most directly affected members and/or those with possible legislative influence. The membership at large sometimes was unaware of the deliberations until after the decisions had been made, or they were asked to respond only after directions had been well established and there appeared little possibility of exerting significant influence.

Several specific strategies have been designed to advance the objective of assuring that the Council of Deans serves as the deans professional society:

- The COD Spring Meeting with its mix of program, business and unscheduled time designed to facilitate maximum interchange among the deans.
- The establishment of the AAMC's Management Education Programs recently recast to emphasize the continuing education function of the program.
- The new deans "package" and orientation program.

Most recently the Board has considered approaches which would enhance this objective:

- A proposed new session at the annual meeting emphasizing dialogue and deliberation in contrast to routine business and reports.
- A new level of responsibility and accountability on the part of the Board members for communication with the membership as a whole.
- Acceptance of a greater level of responsibility on the part of Board members for the initiation of new Council members into the club.

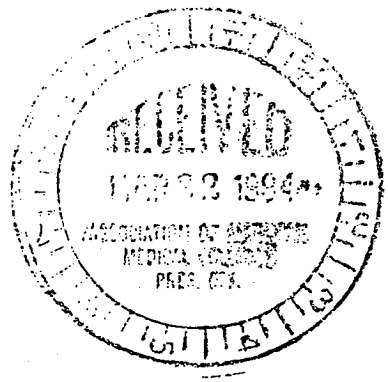
Issues:

- Are the affairs of the Council of Deans conducted so as to realize the goal of the Council serving as the deans' professional organization?
  - Are approprite meeting sites chosen, issues identified, speakers selected, opportunities for effective dialogues offered?
  - Do appropriate mechanisms exist for involving the deans in AAMC issue selection and analysis? Policy setting deliberations?
  - Are the deans adequately informed of AAMC activties?
  - Are the deans adequately staffed and given support for their involvement in AAMC programs?
- With respect to the AAMC as a whole, is there a proper balance between its various programmatic activties?

BROWN UNIVERSITY *Providence, Rhode Island • 02912*

Division of Biology and Medicine

David S. Greer, M.D.
Dean of Medicine



March 20, 1984

John Cooper, M.D., Ph.D.
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

In the past year we, at Brown University, have noted increasing activity in our international relations. During the last several months alone, I have been visited by representatives of medical schools in South Korea, Columbia, El Salvador, Nicaragua, and both East and West Germany. This is in addition to on-going programs we have in Brazil, Sweden, Great Britain and other countries.

The problems and the needs are varied but can be categorized as follows:

Medical schools in developed countries appear to be increasingly interested in student exchange.

Medical schools in more rapidly developing countries are interested in specialty training for post-doctoral students and junior faculty.

Schools in less developed countries are often looking for educational consultation and materials which will enable them to further develop their medical education programs, e.g., we have invited two Deans to come to Brown and meet with our course leaders who will review the curriculum and provide them with samples of the printed material used in our courses.

Medical schools in revolutionary societies need not only educational consultation but also money and equipment, e.g., the school in San Salvador was invaded and destroyed by the military three years ago and now operates out of the general hospital and several dispersed sites but has lost most of its equipment.

My experience as one of the founding directors of the International Physicians for the Prevention of Nuclear War has convinced me that physicians can make unique contributions to the resolution of international problems while neither being politicized nor parochial in their approach. The current state of medical education in many areas of the world cries out for assistance which I believe would ideally be initiated and organized by the AAMC. Indeed, the marriage of the perceived American problem (a surplus of educational facilities, students and physicians) and the problems in many other countries of the world (lack all of the above) would appear to be a perfect union of interests.

I envision the exchange of students and faculty, the provision of textbooks and other written materials, solicitation of foundation and private support for equipment, etc. through academic channels which we would strive to keep separate from political and ideological differences. My experience with academics on both sides of the iron curtain and in developing countries has encouraged me to believe that this is possible; most of the people I meet share my ideals and my professional objectives regardless of the politics of their national origin.

Does the AAMC have a program of this kind that I am unaware of? If not, do you feel it is worth discussing? Possibly, it might be put on the agenda of the Council of the Deans meeting next month. Brown University has a rapidly developing international studies program, stimulated by the interest of President Swearer who was a Soviet expert prior to becoming a bureaucrat. We, therefore, have a mechanism in place and I believe would be pleased to assume the obligation of initiation of a program of this kind nationally.

Warm personal regards,

Sincerely yours,

David S. Greer, M.D.
Dean of Medicine

DSG/amd

association of american medical colleges

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

March 26, 1984

(202) 828-0460

David S. Greer, M.D.
Dean of Medicine
Brown University
Providence, Rhode Island 02912

Dear Dave:

Thank you very much for your letter about international relations in medical education and medicine.

I would like to answer your questions in the last paragraph of your letter. The AAMC does not now have a program in international medical education. We had a program for many years which was initiated by Dr. Henry van Zile Hyde and which continued after his retirement under the direction of Dr. Emanuel Suter. After a discussion at an annual retreat of officers on projections of the fiscal status of the AAMC, it was decided to abandon the Division of International Medical Education because outside funding support to carry the majority of the costs could not be obtained. We found that AID and foundations were more interested in giving money directly to institutions than to an umbrella organization like the AAMC.

I have talked with Joe Keyes about your suggestion that this matter be placed on the agenda for the COD meeting next month. If it is agreed that it should be on the agenda, I hope that you will be there to discuss your views and recommendations.

Despite the fact that we do not have a Division of International Medical Education, we, too, are visited by a great number of representatives of foreign medical schools and ministries of health and education. As you probably know, I have had a long interest in international affairs and have spent a great deal of time working with institutions in South America, the Middle East, and Kenya. Through my participation in the WHO working group on tropical disease research, I have been involved in trying to provide equipment and support to investigators in developing countries to develop or strengthen their ability to do good biomedical research. As you probably remember, the AAMC helped to establish the Panamerican Federation of Associations of Medical Schools. I was a founding member of its Administrative Committee and have been its Treasurer for a number of years.

One Dupont Circle, N.W. Washington, D.C. 20036

I just wanted you to know that we try to maintain our contributions to our colleagues in other countries.

Sincerely,

John A. D. Cooper, M.D.

AAMC CLINICAL EVALUATION PROGRAM

The Association of American Medical Colleges (AAMC) Clinical Evaluation Program is designed to assist clinical faculties in evaluating students during their undergraduate and graduate clinical education. The completion of Phase I of the program, during which participants identified general problems in the evaluation of clerks and residents, was marked by the distribution of 7,000 copies of the booklet, The Evaluation of Clerks: Perceptions of Clinical Faculty (AAMC, 1983), and of the accompanying editorial, "Clinical Judgment of Faculties in the Evaluation of Clerks" (Journal of Medical Education, March 1983).

The pamphlet "Clinical Faculty Invited to Join Expanded Program" was distributed in Winter of 1983 to the Council of Deans, the Council of Academic Societies, the Council of Teaching Hospitals, the Group on Medical Education, and the Chairman's group from medicine, surgery, pediatrics, psychiatry, obstetrics-gynecology and family medicine. The purpose of the pamphlet was to provide an overview of Phase II of the program so that persons representing clinical training sites, clinical departments, hospitals or medical schools could indicate their interest and the extent to which they wished to participate in the program.

As of March, 1984, 115 U.S. medical schools, 14 Canadian medical schools and 45 hospitals are represented among the respondents. AAMC staff is in the process of contacting those interested in program activities. Staff is also summarizing the information obtained from the tear sheet questionnaire (last page of the pamphlet) which includes

the type and extent of reviews of clinical evaluation policies and procedures being conducted and opinions about the most pressing concerns in matters of clinical evaluation of medical students and residents.

Contact persons from six medical schools are working with AAMC staff to develop strategies for piloting the self-assessment materials for Project A. The Self-Assessment of Clinical Evaluation Systems. Two schools have collected initial data. An update on these activities will be presented at the Council of Deans' Spring meeting in April, 1984.

Specialty Residency (PGY2) Match of Medical Students

At its September meeting, the AAMC Executive Council adopted two recommendations to address a series of concerns regarding the practice of selecting medical students early in the senior year for the second postgraduate year. These actions were taken in response to concerns raised by the deans regarding the impact of these practices on the educational program of the senior year and coordination with the National Resident Matching Program (NRMP) match. The first was a recommendation that the NRMP establish an Advisory Panel consisting of a representative of each of the specialities offering an approved residency program (whether or not filling its positions through the NRMP match). The second was a recommendation that the AAMC Executive Committee invite representatives of the specialties of dermatology, neurology, neurosurgery, ophthalmology and otolaryngology to meet with it and a representative of the Group on Student Affairs (GSA) and the Organization of Student Representatives. Both recommendations were designed to pursue the resolution of educational concerns by fostering greater communication between those with varying perspectives.

On December 7, the AAMC Executive Committee held an invitational meeting as had been recommended. Two representatives of these societies attended and explained in detail their own views of the advantages of an early (senior year) match. The neurologists reported on an indepth study of the preferences of both program directors and current residents on this issue which disclosed the potential desirability of having two matches--one in the senior year--one in the first postgraduate year--to accommodate all of the preferences. The dermatologists reported the decision of the program directors in that specialty to substitute a match in the first postgraduate year for their current senior year match. The neurosurgeons, ophthalmologists andotolaryngologists emphasized the factors that underlay their current match procedures.

The student, GSA and neurology representatives cautioned the other society representatives that the data on candidate satisfaction collected in conjunction with the selection process should be received with a large measure of skepticism. The AAMC staff and leadership, while refraining from exerting any pressure on the selection of the NRMP as the matching mechanism, emphasized both the receptivity and the technical capability of the NRMP to accommodate a much more flexible response to program directors' interests than might have been perceived.

The participants endorsed the AAMC proposal that the NRMP establish an Advisory Panel of program directors on each of the specialties. There was widespread agreement that a productive dialogue had been initiated.

The NRMP Board will discuss the Advisory Panel at its meeting on April 24. It has been suggested that the specialties using early senior year matches should meet again to address constructive resolution of the educational concerns.

MEETING OF THE AAMC EXECUTIVE COMMITTEE
WITH REPRESENTATIVES OF FIVE ACADEMIC (CLINICAL) SOCIETIES
DECEMBER 7, 1983

Minutes

Dr. Heyssel opened the meeting at approximately 12:45 after most of the participants had arrived and had engaged in informal conversation over lunch. He asked the participants (Listed - Attachment A) to introduce themselves in order around the table, giving their name and affiliation (institution and specialty represented). Dr. Heyssel then expressed his and the Association's appreciation for the willingness of those present to devote the time and energy required to make this dialogue possible. He emphasized that the AAMC's objective in asking for the meeting was to facilitate maximum communication and understanding among groups with varying and sometimes conflicting perspectives on the matter of matching senior medical students into residency positions at the second postgraduate year. Generally stated, the AAMC was seeking an approach which provided:

(1) Students with maximum time and opportunity to make appropriate career choices;

(2) Program directors with maximum opportunity to evaluate and select appropriate candidates for the available positions;

(3) Medical schools with the latitude to provide their students with a sound medical education and to provide program directors with an academic evaluation of candidates grounded in accurate assessments of students in appropriate situations.

Observing that the Neurologists had recently completed an extensive survey of both program directors and resident physicians in that specialty, Dr. Heyssel asked Dr. Thompson and Dr. Dyken to address the concerns of that group first. Dr. Dyken provided a detailed description of the survey and its results. (See Attachment B.) He pointed out, in particular, that the characterization of the findings contained in the AAMC pre-meeting material, while consistent with his own first thoughts, turned out to be not entirely accurate when tested at the program directors' meeting in November. Specifically, the observation that the directors would prefer a late match over an early one and a single match over two matches, while true on a majority/ minority basis, warranted further examination. In actuality, there was a distinct bi-modal distribution of the responses and subsequent discussion disclosed a substantial willingness among the members to accommodate the interests and objectives of each other. This may well result in a decision (at the spring meeting of the program directors) to adopt a bi-phasic match system which would entail a match at both the senior and the PGY-1 years. A condition of such a system would be that program directors reserve at least one position in the second match. Preliminary discussion indicated that the program directors would be generally amenable to such a system. This is based in part on the experience that approximately a third of the positions are now filled by the current match.

Drs. Dyken and Thompson also reported on the results of the 1983 match which had just occurred, and the reasons they adopted the current system. It was their perception that the NRMP was unreceptive to meeting their unique needs and that the experience of others using the services of Dr. Colenbrander had been highly satisfactory. Their own experience with this alternative bore that out since they were impressed with the personal attention and responsiveness of Dr. Colenbrander.

Dr. Freedberg, representing the Dermatologists, was the next discussant. His society had two years of experience with the Colenbrander match and had recently decided to switch to the NRMP. He reported that, contrary to the impression held by the neurologists, the view of his organization was that the NRMP was extremely responsive to the needs of program directors. This view was shared by program directors in pulmonary medicine who had recently conducted an NRMP match for candidates interested in entering that specialty. Extensive discussions are currently under way to accomplish an NRMP-managed match of Dermatology candidates to be conducted during their first post-graduate year. All indications were that this match would go very smoothly.

Dr. Clark and Dr. Pevehouse, representing the Neurological Surgeons, indicated that they had selected the Colenbrander system for its apparent responsiveness to their concerns. Their first match was just recently concluded. It had apparently gone very well. They had not previously used a computer match with a uniform match date and were impressed with the ease of such a system. Their primary motivation was to conduct a match in advance of the NRMP to permit students to select a first year position based upon their neurosurgery program match for convenience of coordination of first and second year positions. (Coordination of the educational experience and minimizing geographic dislocations.) Since the NRMP system did not adequately accommodate this objective, the neurosurgery program directors had adopted the approach of the ophthalmologists. Dr. Pevehouse also described in detail the educational objectives which the neurosurgeons felt had been frustrated by the decision to abandon the internship as a freestanding broad-based experience and the inadequacy of the fourth year of medical school to accomplish the goal of broadening the clinical experience of medical students. In his view, much of the turmoil would be resolved if there were a return to the prior system or if there could be established an adequate level of cooperation between the directors of programs in general surgery to meet the needs of the neurosurgeons.

Dr. Cummings spoke for the Otolaryngologists. He described the inability of the NRMP to meet the needs of the otolaryngologists. He described the inability of the NRMP to meet the needs of the otolaryngologists when they were prepared to join the match. This led to the adoption of the Colenbrander system which had, for them, proven satisfactory thus far, although this is their first year and the match results are not out yet. He expressed interest in the testimony regarding the NRMP's current responsiveness, but suggested that any modification of the otolaryngologist's position did not appear imminent. He did, however, acknowledge the desirability of a more coordinated approach which satisfied the interest of all parties to the transactions.

Dr. Snow reiterated the view that the Otolaryngologists' adoption of the Colenbrander system resulted from the lack of effective response of the NRMP to their needs.

Dr. Kalina, representing the Ophthalmologists, the group which had first initiated a matching program at the PGY-2 level, reiterated the views of others who had subsequently adopted that system: that it was in the students' interest; that it had proven satisfactory to the program directors; and that the candidates, when surveyed, preferred the present timing of the match to a later match. This latter comment drew a response from the Neurologists that any opinion from the candidates, developed during the course of the selection process, should be treated with great caution. The experience of the Neurologist's survey was that opinions given anonymously and outside the match process tended to differ markedly from those collected in the context of the match.

This comment was endorsed by Ms. Close, representing the OSR. While disavowing any ability to represent a unitary "student perspective," she observed that the students would predictably adopt a view which seemed most calculated to advance their own, immediate self-interests. She asked the participants to be cognizant of the burdensome and anxiety-producing nature of the current fourth year interviewing and fragmented specialty selection process. She opined that the system frustrated important educational objectives, was very expensive for the students, and was significantly disruptive of both student equanimity and student satisfaction with the medical education process.

Dr. Keimowitz, speaking on behalf of the Group on Student Affairs, urged the participants to recognize the frustrating nature of the current, fragmented system. He stated that, despite any flaws that the NRMP might have, it did represent a single contact point for student affairs deans for most problems regarding the match. This is of great value to the student affairs deans. A major deficiency of the overlapping or competing match was the student affairs deans' difficulty in managing his/her responsibilities for advising and assisting students through this transition. Lastly, Dr. Keimowitz urged that the match process occur as late as possible, consistent with the other demands on the students and program directors, and that there would be considerable benefit to everyone if all programs operated on a timetable similar to NRMP's.

Dr. Heyssel asked Dr. Short of the AAMC staff to lay out the AAMC position. After a demurrer that her assignment was to describe the NRMP's current technical capabilities -- and to remove some unfortunate misperceptions regarding the NRMP -- not to advocate NRMP utilization as the AAMC position, Dr. Short proceeded to describe the NRMP's current "Advance Student Match" by means of a simple diagram (Attachment C). There followed a discussion of the extent of the current use of this approach. It became apparent that there was almost no use of this comprehensive NRMP match system because an early version had been poorly received in its initial presentation by NRMP in 1982. There was general discussion of the flexibility of this system which could coordinate a match of internship and a separate match for residency in one computer run, and which would also permit students the opportunity to use full (categorical) medicine or surgery programs as "back-up" for their specialty residency choices. It was

acknowledged that this option proved especially useful in such specialties as ophthalmology where the number of applicants far exceeded the number of positions. The Neurosurgeons and Otolaryngologists expressed the desirability of their programs receiving residents from a general surgery background. It was agreed that nothing in the current match systems prevented this, but that any problems lay in coordination between the surgical specialties and the general surgery department to offer a proper career path to candidates.

Dr. Short also emphasized her view and that of the student affairs deans that the early match did not accomplish the objectives set out by the Neurosurgeons and the Ophthalmologists' representatives. She pointed out that the system which matched students to PGY-2 positions in the time frame of mid-November to late December did not reduce the interviewing burden of the students because by that time the interviewing for PGY-1 positions was essentially complete. Thus, the two-to eight-week period between the early match results and the submission of the NRMP preference lists created only an illusory advantage to the students. It is true that knowing the PGY-2 position allows the students to create a PGY-1 preference list with greater certitude at the time of submission. However, it lessened no travel or interviewing burden and created the necessity of participating in two matching processes. The advance student match of the NRMP, while slightly more complex, accommodated at one time all of the objectives related to coordinating positions at the PGY-1 and PGY-2 years. It allowed for a more flexible and somewhat more leisurely interviewing schedule and permitted maximum coordination of the matching system. The NRMP dates also allowed maximal time for students to complete the standard junior year medical school curriculum and to even try several electives in the career fields they were considering before having to make career decisions in early Fall of the senior year. Under the NRMP match timetable Dean's Letters could be sent in early October and include student evaluations from 14-15 months of clinical work.

Several program directors responded somewhat skeptically. Dr. Snow pointed out that the number of supplementary lists -- PGY-1 choices coordinated to the PGY-2 positions -- was limited under current rules. Dr. Short responded that this was not inherent in the match algorithm but was adopted this year purely for administrative convenience. It need not be so limited next year. Program directors also pointed out that the potential for listing up to twenty positions on each supplementary list created a mind boggling number of combinations. Dr. Short suggested that this was conceptually accurate but that the reality was that it did not materially affect the situation students actually faced irrespective of match algorithm or system. Students were already applying to a recommended number of PGY-2 residencies and to all the internships necessary to pair with each of these PGY-2 choices.

The meeting disclosed widespread and shared agreement that the transition from medical school to specialty choice is currently complex, difficult and frustrating for students, fraught with negative impact on the student educational objectives, and deserving of attention from leaders in the medical education establishment. There was uniform enthusiasm for the concept of selecting residents by some computer match system which insured a single date for matching for a specialty rather than the previous open offer

system. There was agreement that this kind of dialogue should prove to be an important first step in addressing such problems. Ultimately, there should be a system with the qualities initially highlighted by Dr. Heyssel and such a system should permit maximum coordination among parties involved.

Dr. Heyssel asked the society representatives if they concurred in the AAMC suggestion that the NRMP ought to establish an advisory panel made up of representatives of each specialty with a residency program whether or not the specialty participated in the NRMP match. There was unanimous agreement with this proposal, it being understood that participation on the panel did not commit the specialty to participation in the NRMP match.

The meeting was adjourned at 3:15 with general expressions of satisfaction that an important dialogue had begun.

STATEMENT OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Presented by

ROBERT M. HEYSSEL, M.D.
Chairman

Before the

INSTITUTE OF MEDICINE
COMMITTEE ON THE IMPLICATIONS OF FOR-PROFIT
ENTERPRISE IN HEALTH CARE

March 15, 1984

COMMITEE ON THE IMPLICATIONS OF FOR-PROFIT
ENTERPRISE IN HEALTH CARE

March 15, 1984

Good morning. I am Robert M. Heyssel, MD, President, The Johns Hopkins Hospital, and Chairman of the Association of American Medical Colleges. The AAMC is pleased to have this opportunity to tesify before the Committee. In addition to representing all of the nation's medical schools, and 76 academic societies, the Association's Council of Teaching Hospitals (COTH) represents 350 state, municipal and not-for-profit hospitals, and 71 Veterans Administration Medical Centers.

Before beginning, I wish to make my views clear on a couple of matters. I'm not here with the view that profits are evil. First, the hospital and physician environment is surrounded by and interwoven with profit-making enterprises. I think it's fair to say the same is true of universities; anyone who isn't aware of that hasn't looked too closely at the financial relationships that have developed between universities, their faculties, and embryonic as well as well-known corporations. Second, profit is necessary even for non-profit hospitals: to launch new programs, maintain a modern and effective physical plant, and to develop new ideas. The Johns Hopkins Hospital generated almost a $6.4 million profit on operations in 1983 and has consistently had profits from operations for 10 years. This return was earned by efficient operations performed within the revenue limits approved by the Maryland Health Services Cost Review Commission. I would call to your attention that this is an operating margin of roughly three percent.

Neither am I here this morning to discuss the pros and cons of all aspects of the impact of the for-profit enterprises on health care, which is your Committee's title. I am here to discuss the issues which worry and concern me as I think about the implications of investor-owned acute care hospitals. I do wish to share with you two brief illustrations which will give you an idea of where my presentation is headed. First, I'd like to refer back to the $6.4 million profit on operations that we earned at The Johns Hopkins Hospital last year. You may not be aware of this, but I'd like for you to know that we had an opportunity to raise our prices during the year, and stay within the Cost Commission's limit on rates. That would have increased our profit margin significantly. We chose not to do so. Why? Because in our view, based on our mid-year projections and our then current charges, our operating margin would satisfy a target need we had set based on a variety of assumptions about our future financial requirements. I ask you, "Would that have been a recommendation that management would make, or that the Board would adopt if we were an investor-owned corporation?" I have my own opinion, but I'll leave the question for you to answer.

The second illustration is somewhat more complicated, but suggests some issues to think about in a very compelling way. Last April, Cedars-Sinai Medical Center in Los Angeles failed to win a Medi-Cal inpatient service contract from the State of California under the newly developed "price competitive" bidding arrangements.

Thus the hospital started referring all Medi-Cal inpatients and outpatients to other hospitals that negotiated inpatient contracts. The decision not to serve outpatients was controversial because the state continues to reimburse hospitals that see outpatients regardless of whether the hospital has an inpatient contract. Cedars-Sinai stated it would be unethical for the hospital to continue to see outpatients when it could not guarantee their continuity of care if inpatient services would be required, since most of the physician and resident staff do not have appointments at other hospitals.

I am well acquainted with Stuart Marylander, the chief executive of Cedars-Sinai Medical Center. He is an extremely competent and compassionate man. I understand the pressures the hospital was under, and the reasons for the decision. The response to the decision, however, created considerable controversy. A number of Jewish community organizations and publications expressed views ranging from concern to outrage. Substantial apprehension was expressed over the inability of a hospital which has historically provided services to all patients to continue to do so. It's important to realize that the hospital clinics never closed. Patients without health care coverage of any sort continued to be served. It was only patients covered under the Medi-Cal program that were affected.

The resolution to this controversy is state approval of a subcontract between UCLA Medical Center, a Medi-Cal contracting hospital, and Cedars-Sinai Medical Center which will allow Cedars-Sinai to treat Medi-Cal patients through its ambulatory care center. There are many sides to this story which I'm sure are unknown to me, and in this regard I suggest readers review the open letter to the community on this subject which is attached as Appendix A to this testimony. However, I think there are some central questions to think about.

- o If Cedars-Sinai Medical Center were a corporation owned by a group of investors, would this controversy have ever arisen?

  I seriously doubt it.

- o If Cedars-Sinai and UCLA Medical Centers were investor-owned corporations (or even if one of them were), would the cooperative arrangement to solve the problem have been possible?

  I seriously doubt it.

- o What does this experience tell us about the role of the hospital in the community?

  Cedars-Sinai Medical Center is woven into the very fabric and sociology of the greater Los Angeles community. I think this kind of hospital/community relationship is one upon which we should place a very high value. I do question whether such a relationship can be sustained or developed if the hospital is owned by a group of investors.

Along a different dimension, but on the same point, I was interested in the view of one of the physicians who participated in the purchase of Coral Reef Hospital

in South Miami, Florida. According to a report in the February issue of American Medical News, he said, "We were tired of being sold every few years to another corporation." I realize when I make this point that in this case the for-profit status of Coral Reef Hospital didn't change. However, the case does demonstrate the kind of ownership instability that concerns me as I think about the relationship of the hospital to the community and its physicians.

It is fair to say that until recently, the vast majority of hospitals were not built and developed to make a profit. Notwithstanding very recent events, this continues to be the case for teaching hospitals. And teaching hospitals have taken pride in their accomplishments in the development of tertiary care services, provision of educational programs, efforts in clinical research and technology transfer, and their role in providing service to the poor and medically indigent. These are the unique societal contributions that teaching hospitals provide. I'm quite sure these contributions would not be carried out in similar fashion if all our teaching hospitals were owned by investors.

TEACHING HOSPITAL SOCIETAL CONTRIBUTIONS

Tertiary Hospital Services

The teaching hospital's patient care reputation is clear: it is the place for the most severely ill patieints. In a disease staging case mix study of 24 Council of Teaching Hospitals (COTH) members, 12% of the cases in the teaching hospitals studied were in the most severely ill categories and accounted for 20% of total patient days. Half of those patients had either cancer or cardiovascular diseases.

Patients with the most severe medical needs tend to be sent to teaching hospitals for the latest patient care capabilities. In 1980, the 329 non-federal members of the Council of Teaching Hospitals performed:

- o 68% of the pediatric open heart surgeries;
- o 49% of the computerized (CT) scans;
- o 47% of the adult open heart surgeries; and
- o 30% of the computerized (CT) body scans

provided by short-term, non-federal hospitals. Teaching hospitals are also the primary source of microsurgery, joint replacement surgery, transplant surgery, specialized laboratory and blood banking services, and specialized neurological and ophthalmology procedures. TABLE I on page 3a rather dramatically demonstrates the volume of special service contributions made by teaching hospitals.

Full Service Clinical Education

Teaching hospitals are major educational institutions. In 1983, COTH short-term, non-federal hospitals provided the training sites for over 45,000 residents and

TABLE I

Percentage of Short-Term, Non-Federal Hospitals Providing Selected Services by Membership in the Council of Teaching Hospitals 1980

Selected Services	Percentage of Hospitals Providing		COTH as a Percentage of All Hospitals
	COTH Members	Non Members	
Social Work Departments	95%	69%	7%
Histopathology Lab	94	57	9
Electroencephalography	93	57	9
Diagnostic Radioisotope Facility	91	57	9
Emergency Service			
24 Hour Physician Coverage	91	48	10
As Organized Department	90	70	7
Blood Bank	88	70	9
Hemodialysis—Inpatient	85	18	22
Cardiac Catheterization Facility	83	11	31
Organized Outpatient Department	82	42	10
Therapeutic Radioisotope Facility	80	20	19
C.T. Scanner	80	17	22
Premature Nursery	78	34	12
Radioactive Implants	77	20	23
X-Ray Radiation Therapy	75	15	22
Megavolt Radiation Therapy	71	11	27
Open Heart Surgery Facility	67	6	39
Hemodialysis—Outpatient	66	8	32
Genetic Counseling	53	4	45
Organ Bank	28	2	46
Burn Care Unit	23	1	58

Source: 1980 Annual Survey of Hospitals, American Hospital Association.

fellows in graduate medical education programs, over 30,000 students in the last two years of medical school, and large numbers of nurses and allied health students. As major teaching hospitals, non-federal COTH members are active participants in multiple residency training programs; 6% of the hospitals participated in at least 26 residency programs; 41% participated in 16 or more programs. At least 70% of the COTH hospitals provided programs in the basic specialties of internal medicine, general surgery, obstetrics-gynecology, pathology, orthopaedic surgery, and pediatrics.

The clinical education of medical, nursing and allied health students is organized around the daily operations of the hospital. Patients are being treated and students are being trained through the same activities. In effect, both products - patient care and education - are being simultaneously, or jointly, produced. The joint nature of patient services and clinical education does not imply that education is being produced without additional costs - education is not simply a byproduct. The addition of the educational role does involve additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. It is most difficult, however, to identify distinctly many of the educational costs because of the impossibility of a clear separation of clinical care from clinical education. It is also difficult to quantify the service benefits teaching hospitals receive from physicians, nurses, and technicians in training programs.

Residents learn clinical skills through supervised participation in the diagnosis and care of patients. The patient service benefits that accompany this learning reduce, in some part, the costs of graduate medical education programs. The cost reduction varies with the patient's clinical needs and the resident's level of training. Service benefits provided by residents are probably more substantial for tertiary care patients requiring continuous medical supervision than for routine patients and are greater for senior residents than junior residents. While there is no conclusive study comparing the costs added by residency programs with the service benefits provided by residents, hospital executives and medical educators generally believe that the costs of operating a residency program exceed the service benefits obtained by patients. This added cost is the investment necessary to adequately prepare the future generation of professional health personnel.

Clinical Research and Applied Technology

The reputation of teaching hospitals for state-of-the-art medical care is world-renowned but difficult to quantify. Hospital industry questionnaires generally do not inquire about new, rare, or unique services. Occassionally, a national inventory does provide some insight. For example, in 1980, the US Public Health Service published a list of clinical genetic service centers. Of the 223 listed centers, 82 were hospital programs with 57 of these (70%) sponsored by members of the Council of Teaching Hospitals. An additional 36 programs were located in state agencies, private health agencies, and private research institutes. The largest concentration, 105 programs, was located in universities, but in these university programs, the roles of their teaching hospitals were not separately identified.

The clinical genetics data illustrate the problem of identifying the teaching hospital's role in clinical research. In most cases, the university's clinical faculty are also the hospital's medical staff. The specific identification of research program location may reflect more upon the flow of grant funds (e.g., National Institutes of Health to university) than on the actual site of the research (e.g., university or hospital). Data on clinical research derived from funding flow typically understate the teaching hospital's role.

The presence of medical research in the teaching hospital has environmental, managerial, and financial implications. To attract and retain research-oriented faculty physicians, the hospital must create and maintain a climate conducive to research. Research scholarship must be esteemed, research support and supplies must be readily available, and individual hospital departments must be flexible and responsive to the demands accompanying research. Managerially, the inclusion of medical research in a teaching hospital's primary mission requires governing board and senior management commitment to integrating research into the daily operations of the hospital. Specialized supporting staff must be hired and trained, necessary research review and patient protection procedures must be developed and monitored, record-keeping and reporting by the funding organization must be established, and management styles appropriate for personalized and efficient patient care must be balanced with a collegial style appropriate for research productivity. Without an appropriate environment and management, research will not flourish.

Establishing a medical research program increases a teaching hospital's costs. Additional costs are incurred for staff, supplies and equipment, space maintenance and upkeep, and record keeping. Most, but not all, of these added costs are supported by grants, contracts, endowments, and gifts. Regular hospital services provided for research patients are generally paid by the patient or his third party coverage.

There is much to be said and understood about this subject. However, the point I wish to leave with you is that without an appropriate environment and management attitude, research simply will not flourish.

Charity Care

Providing service to low income patients is not a responsibility which is distributed uniformly across all hospitals. Teaching hospitals care for a disproportionate number of the poor. Non-federal members of the Council of Teaching Hospitals have 19% of the nation's short stay beds but 25% of the Medicaid admimissions. In addition, teaching hospitals have a disproportionate share of the patient bad debts and charity care (TABLE II). In 1980, COTH members wrote off 47% of the charity care ($601 million) and 35% of the bad debts ($1,176 billion) incurred by all short-term, non-federal hospitals. As a result, the average COTH member deduction of 9.4% of revenues for charity and bad debts was 84% greater than the hospital average deduction of 5.1% of revenues.

Having made this point on behalf of teaching hospitals, it also needs to be pointed out that this responsibility is not equally shared within the teaching hospital community. There are some institutions, particularly some urban hospitals, which carry an inequitably large share of this responsibility.

TABLE II

Bad Debt and Charity Deductions for Short-Term, Non-Federal Hospitals by Membership in the Council of Teaching Hospitals 1980

	COTH Members	Non-COTH	Total
Number of Hospitals	327	5,503	5,830
Deductions for Bad Debts	$1,176,457,285	$2,147,076,975	$3,323,534,260
Deductions for Charity	600,830,737	673,420,989	1,274,251,726
Total Net Patient Revenue	18,935,681,665	54,883,157,724	73,818,839,389
Percent of Hospitals	5.6%	94.4%	100.0%
Percent of Bad Debts	35.4%	64.6%	100.0%
Percent of Charity	47.2%	52.8%	100.0%
Percent of Net Patient Revenue	25.7%	74.3%	100.0%
Bad Debt and Charity as a Percent of Net Patient Revenue	9.4%	5.1%	6.2%

Source: 1980 Annual Survey of Hospitals, American Hospital Association

DISCUSSION

I have taken much time to describe the societal contributions of teaching hospitals. I have done so to be sure certain questions get proper attention. In the excellent Institute of Medicine publication on the subject before us today, Professor Luft states, "After all, the concerns about for-profit enterprises in medicine stem largely from the notion that care will suffer." At the level of the patient-physician relationship, this is correct; however, in a broader societal context, the question becomes, "Will certain desirable functions be continued?" In the abstract, it's a bit too easy to say, "Sure, clinical research will move ahead, new tertiary services will be available, manpower will be trained and educated, and someone will take care of the poor." Those words roll out so easily, and more recently, with greater and greater frequency. However, the financing arrangements and characteristics of the hospital environment which have enabled us to support these important societal contributions of the teaching hospitals are beginning to shift, and changes are occurring rapidly.

With the exception of research grants and contracts, and state and local government support for a relatively small number of hospitals, patient service revenue in the teaching hospital is the dollar stream that supports these very necessary societal contributions. "Cost-shifting" or "charge-shifting," whatever term you prefer, is in fact taking place, as the Health Insurance Association of America (HIAA) has charged. However, it's not quite as undesirable as the insurance executives allege, and there is some more to it. In the final analysis, it does not come down to need for a profit (all hospitals need a profit), but to the question of what one does with the money. I understand the other side of the HIAA argument, but let's again ask some basic questions:

- "Is it wrong to charge one group of patients higher charges so another group of patients can be served?"
- "Is it wrong to finance education from higher charges to patients, particularly when other sources of financing are not available?
- "Is it wrong to finance some clinical research and development from patient revenue?"

Essentially, what we're doing here is subsidizing several functions with revenue from one function. However, these cross-subsidy choices are less and less available as the environment changes to reflect an attitude where competition is strictly on the basis of price. Suffice it to say that although price competition may stimulate prudent decisions by educated consumers and groups with purchasing power, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet the needs of all our citizens.

More to the point of this hearing, however, is Shortell's distinction between investor-owned and voluntary hospitals:

A basic distinction between investor-owned and voluntary hospitals is the former's need to make a return on stockholders' equity. This return might be viewed as the ultimate goal of the investor-owned hospital with the rendering of patient care serving as an instrumental goal or means of achieving the ultimate goal of return on equity. In contrast, for the voluntary hospital the ultimate goal is the delivery of patient care to the community and generating a surplus (or profit) serves as an instrumental goal or means by which this is achieved. In brief, the means-ends relationships become reversed.

It is important to note that for both investor-owned and voluntary hospitals, financial viability and the delivery of cost-effective patient care are important, whether as instrumental or ultimate goals. Nevertheless, one might hypothesize that this difference will affect the decision-making process and the resulting choices of specific services offered by hospitals. The investor-owned hospital will presumably be particularly interested in adding services that will increase return on investment.

Some observers might suggest that the strategies that not-for-profit hospitals are using to overcome certain disadvantages resulting from their organizational form are blurring the differences between not-for-profit and investor-owned hospitals. Blurred perhaps, but the fundamental difference remains, and that difference is exemplified by the basic purpose and mission of an investor-owned corporation. I would suggest that the investor-owned corporation has a legal obligation to its shareholders. Each decision that a corporation makes with regard to service mix, program selection, and population served will have an impact on earnings per share. I would agree that some of these decisions can be made in the "loss-leader" context. However, the need and responsibility to make a profit for the shareholders must be the overriding factor in these decisions.

Let's take this thought a bit further. It has become almost conventional wisdom to say that hospitals can no longer think of themselves as community service organizations if they hope to compete successfully for the shrinking pool of capital funds. David Winston, Senior Vice-President for Planning, Voluntary Hospitals of America, was recently quoted as saying, "All of us in health care have to abandon forever the idea that health care is not a business. It is a business, and we have to treat it as such." I agree with the intent of that statement with regard to the competition for capital, but I think we need to examine carefully the "business world" before we fully adopt all of its characteristics. HCA Chairman Donald MacNaughton has said, "I hope at some point the myth relating an aura of purity to an IRS tax exemption is dispelled. As a result of the myth, many hospitals are run loosely as social institutions with an economic burden. HCA operates its hospitals as economic institutions with a social responsibility." In my own view, the question is how "businesslike" can we in the teaching hospital community become, and maintain our multiple missions and societal contributions?

I could move now into the allegations concerning overuse of technology, skimping on quality, cream skimming and conflict of interest that may accompany the profit motive. I'm not satisfied that there aren't some problems in these areas.

However, Professor Veatch has outlined the issues that are of greatest interest to me in his paper on "ethical dilemmas." It would be my suggestion that this Committee pursue vigorously the themes outlined under the heading "Differences Between Business and Physician Ethics." A number of subjects are addressed; however, those that most closely parallel the concerns set forth in this paper are as follows:

- exclusion of inefficient customers;
- supplying unprofitable products and services; and,
- the duty to the indigent.

In this regard, Bob Cunningham, a long time observer of the medical and hospital scene has outlined the situation very well. He said, "What got doctors and hospitals to the special place they have always held in society, and still have, was not tidy balance sheets and debt-equity ratios. As long as they can keep on giving the people, the ultimate scorekeepers, what is new, what is best, and what is needed for all of them, doctors and hospitals can keep the public trust...at any price! If they don't, they won't...also at any price." Thus, my basic concern here is that we continue to provide the mix of products unique to the teaching hospital mission: service to all patients, tertiary care services, manpower for the future, and an environment which allows research to flourish. If we are able to do so, we will keep the public trust that has been placed in us.

CEDARS-SINAI MEDICAL CENTER

Reply to:
Box 48750
Los Angeles, California 90048

Direct Dial Number:

February 17, 1984

LETTER TO THE COMMUNITY

We are writing to clarify some recent public misunderstanding about Cedars-Sinai Medical Center resulting from inaccurate reporting on certain elements of the press. From the opening of Kaspare Cohn Hospital, Cedars' predecessor, in 1902, and Mount Sinai Hospital in 1921, Cedars-Sinai has continuously provided care to the indigent Jews of Los Angeles. The medical center has never deviated from its central theme of compassion and charity. For example, last year, Cedars-Sinai provided $3,546,000 for free care to indigent patients. These indigent patients received 6,500 outpatient visits and procedures and were hospitalized over 1,100 days. With the exception of $995,000 received from the Jewish Federation Council and the United Way, this free care was absorbed out of our own resources.

Our clinics never have closed. Both inpatient and outpatient services to indigent Jews who are without health care coverage of any sort have continued without interruption. Many other poor and aged individuals do have health care coverage from governmental sources, under two programs whose recipients are sometimes confused with those without any coverage. Here is a brief explanation which may help.

In 1965 a Federal law created two programs: (1) Medicare, which provided health care coverage for those aged 65 and over and certain disabled people, and (2) Medicaid (Medi-Cal in California) which did the same for certain categories of the poor. Part of the funding of Medi-Cal was from State sources. Before this legislation all of the indigent aged and the poor were dependent on free clinics, either provided by the County, or a few hospitals such as Cedars-Sinai. Since then, those who are really indigent (without such coverage) continue to be dependent on free care, and have been welcome at Cedars-Sinai.

Certain drastic changes were made recently in the Medi-Cal law. Medi-Cal patients now are allowed to go only to those hospitals which have entered into a new type of

8700 BEVERLY BOULEVARD • LOS ANGELES • CALIFORNIA 90048 • TELEPHONE: (213) 855-5000

contract with the State, which provides services to Medi-Cal patients at a fixed daily rate, (generally very low) regardless of the type or extent of services performed. It is with respect to this change in the law and the subsequent effects on Cedars-Sinai that a number of distortions and errors have appeared in the press. The facts are as follows:

Cedars-Sinai entered into intensive negotiations with the State to work out a Medi-Cal contract. We offered a daily rate considerably below our actual costs. We also accepted the requirement that we have an "open medical staff," permitting any qualified physician to admit patients to our hospital, even though we already had a larger number of physicians on our attending staff than any other hospital. However, we did insist that the contract include an upper limit on the number of Medi-Cal patients we would accept in each of our specialized departments. That figure was 70% higher than the number of Medi-Cal patients we had historically treated. We had to insist on the limits because the open medical staff combined with the superb reputation of our institution would probably have filled the hospital with Medi-Cal patients. This invited financial disaster and would have created the potential of crowding out other patients who look to Cedars-Sinai Medical Center for their hospitalization. Despite our protracted attempts to negotiate such a contract, the State denied it to us because of its policy of not accepting any limit on patient numbers in any Medi-Cal contract. This is the only reason we did not receive such a contract.

Under the changed Medi-Cal law, even though a hospital did not receive a contract from the state, it could continue to serve outpatients (those not requiring hospitalization). Nevertheless, on April 1, 1983, when the new arrangements began, Cedars-Sinai discontinued serving Medi-Cal outpatients and made arrangements for them to be treated elsewhere, usually at UCLA Hospital. This was a professional medical decision made in the interest of the patient. Our inability to hospitalize outpatients who later required it, because we had no contract covering inpatients, would have interrupted the continuity of their care and jeopardized their health. It was morally and ethically wrong, and potentially, legally incorrect to dispense outpatient care alone, because it is not possible to determine which Medi-Cal outpatients might later require hospitalization.

Because of this situation, we began negotiations last April with UCLA, which had received a Medi-Cal contract, to enter into a subcontract permitting Cedars-Sinai to resume providing inpatient care to Medi-Cal recipients. Such a subcontract would then enable us to also resume providing outpatient services. Negotiations have gone on for many months and have now been successfully concluded. We expect formal approval from the University of California Board of Regents this month.

Despite inaccurate reports to the contrary, during this entire difficult period we have continued to furnish outstanding care to both outpatient and inpatient indigent individuals who do not have either Medi-Cal or Medicare coverage. As always Cedars-Sinai recognizes its mission to provide quality health care to those who cannot afford it, and to serve the entire community with the highest standard of excellence in hospital care, medical education, and research.

Sincerely,

Robert L. Spencer
Chairman of the Board

Stuart J. Marylander
President

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

ALABAMA		
University of Alabama	*James A. Pittman, Jr.*	
University of South Alabama	*Stanley E. Crawford*	
ARIZONA		
University of Arizona	*Louis J. Kettel*	
ARKANSAS		
University of Arkansas	*Thomas A. Bruce*	
CALIFORNIA		
University of California - Davis	*Hibbard E. Williams*	
University of California - Irvine	*Stanley van den Noort*	
University of California - L.A.	*Sherman M. Mellinkoff*	
University of California - San Diego	*Robert G. Petersdorf*	
University of California - San Fran.	*Rudi Schmid*	
Loma Linda University	*G. Gordon Hadley*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

University of Southern California	*Allen W. Mathies, Jr.*	
Stanford University	*Dominick P. Purpura*	
COLORADO		
University of Colorado	*Norman Weiner (Interim)*	
CONNECTICUT		
University of Connecticut	*Robert U. Massey*	
Yale University	*Robert W. Berliner*	
DISTRICT OF COLUMBIA		
Georgetown University	*John B. Henry*	
George Washington University	*L. Thompson Bowles*	
Howard University	*Russell Miller*	
FLORIDA		
University of Florida	*William B. Deal*	
University of Miami	*Bernard J. Fogel*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

University of South Florida	*Andor Szentivanyi*	
GEORGIA		
Emory University	*George W. Brumley (Acting)*	
Medical College of Georgia	*Fairfield Goodale*	
Mercer University	*William P. Bristol*	
Morehouse	*Louis W. Sullivan*	
HAWAII		
University of Hawaii	*Terence A. Rogers*	
ILLINOIS		
Chicago Medical School	*Marshall A. Falk*	
Loyola University	*John R. Tobin, Jr.*	
Northwestern University	*Harry N. Beaty*	
Rush Medical College	*Henry P. Russe*	
Southern Illinois University	*Richard H. Moy*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

University of Chicago	*Donald W. King*	
University of Illinois	*Phillip M. Forman*	
INDIANA		
Indiana University	*Walter J. Daly*	
IOWA		
University of Iowa	*John W. Eckstein*	
KANSAS		
University of Kansas	*D. Kay Clawson*	
KENTUCKY		
University of Kentucky	Robin Powell ~~*David L. Cowen*~~ *(Interim)*	
University of Louisville	*Donald R. Kmetz*	
LOUISIANA		
Louisiana State - New Orleans	*Paul F. Larson*	
Louisiana State - Shreveport	*Perry G. Rigby*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

Tulane University	*James T. Hamlin III*	
MARYLAND		
Johns Hopkins University	*Richard S. Ross*	
Uniformed Services University of the Health Sciences	*Jay P. Sanford*	
University of Maryland	*John M. Dennis*	
MASSACHUSETTS		
Boston University	*John I. Sandson*	
Harvard Medical School	*Daniel C. Tosteson*	
University of Massachusetts	*Robert E. Tranquada*	
Tufts University	*Henry H. Banks (Acting)*	
MICHIGAN		
Michigan State University	*W. Donald Weston*	
University of Michigan	*Peter A. Ward (Interim)*	
Wayne State University	*Henry L. Nadler*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

MINNESOTA		
Mayo Medical School	*Franklyn G. Knox*	
University of Minnesota - Minneapolis	*Neal L. Gault, Jr.*	
University of Minnesota - Duluth	*Paul Royce*	
MISSISSIPPI		
University of Mississippi	*Norman C. Nelson*	
MISSOURI		
University of Missouri - Columbia	*William Bradshaw (Interim)*	
University of Missouri - Kansas City	*Harry S. Jonas*	
Saint Louis University	*William Stoneman, III*	
Washington University	*M. Kenton King*	
NEBRASKA		
Creighton University	*Richard L. O'Brien*	
University of Nebraska	*Alastair M. Connell*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

NEVADA		
University of Nevada	*Robert M. Daugherty, Jr.*	
NEW HAMPSHIRE		
Dartmouth Medical School	*Robert W. McCollum*	
NEW JERSEY		
CMDNJ - New Jersey Medical School	*Vincent Lanzoni*	
CMDNJ - Rutgers Medical School	*Richard C. Reynolds*	
NEW MEXICO		
University of New Mexico	*Leonard M. Napolitano*	
NEW YORK		
Albany Medical College	*Robert L. Friedlander*	
Albert Einstein Medical College	*Ernst R. Jaffe (Acting)*	
Columbia University	*Donald F. Tapley*	
Cornell University	*Thomas H. Meikle, Jr.*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

Mount Sinai School of Medicine	James F. Glenn (Acting Dean & President)	
New York Medical College	Arthur H. Hayes, Jr.	
New York University	Saul J. Farber (acting)	
University of Rochester	Frank E. Young	
SUNY - Buffalo	John P. Naughton	
SUNY - Downstate - Brooklyn	Richard H. Schwarz (interim)	
SUNY - Stony Brook	Marvin Kuschner	
SUNY - Upstate - Syracuse	George F. Reed	
NORTH CAROLINA		
Bowman Gray School of Medicine	Richard Janeway	
Duke University	Arthur C. Christakos	
East Carolina University	William E. Laupus	
University of North Carolina	Stuart Bondurant	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

NORTH DAKOTA		
University of North Dakota	*Tom M. Johnson*	
OHIO		
Case Western Reserve University	*Richard E. Behrman*	
University of Cincinnati	*Robert S. Daniels*	
Medical College of Ohio - Toledo	*John P. Kemph*	
Northeastern Ohio Universities	*Colin Campbell*	
Ohio State University	*Manuel Tzagournis*	
Wright State University	*William D. Sawyer*	
OKLAHOMA		
University of Oklahoma	*Charles B. McCall*	
Oral Roberts University	*James E. Winslow, Jr., M.D.*	
OREGON		
University of Oregon	*John W. Kendall, M.D.*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

PENNSYLVANIA		
Hahnemann Medical College	*John R. Beljan, M.D.*	
Jefferson Medical College	*Joseph S. Gonnella (Acting)*	
Medical College of Pennsylvania	*Alton I. Sutnick*	
Pennsylvania State University	*Harry Prystowsky*	
University of Pennsylvania	*Edward J. Stemmler*	
University of Pittsburgh	*Donald F. Leon*	
Temple University	*Leo M. Henikoff*	
RHODE ISLAND		
Brown University	*David S. Greer*	
SOUTH CAROLINA		
Medical University of South Carolina	*W. Marcus Newberry, Jr.*	
University of South Carolina	*J. O'Neal Humphries (Acting)*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

SOUTH DAKOTA		
University of South DAkota	Robert H. Quinn (acting)	
TENNESSEE		
East Tennessee State University	Herschel L. Douglas	
Meharry Medical College	Walter F. Leavell	
University of Tennessee	Robert L. Summitt	
Vanderbilt University	John E. Chapman	
TEXAS		
Baylor College of Medicine	William T. Butler	
University of Texas - Dallas	C. Kern Wildenthal	
University of Texas - Houston	Ernst Knobil	
University of Texas - San Antonio	Marvin R. Dunn	
University of Texas - Galveston	George T. Bryan	
Texas Tech University	J. Ted Hartman	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

Texas A & M University	*Robert S. Stone*	
UTAH		
University of Utah	*G. Richard Lee*	
VERMONT		
University of Vermont	*William H. Luginbuhl*	
VIRGINIA		
Eastern Virginia Medical School	*James P. Baker (Interim)*	
Medical College of Virginia	*Leo J. Dunn (Acting)*	
University of Virginia	*Norman J. Knorr*	
WASHINGTON		
University of Washington	*David C. Dale*	
WEST VIRGINIA		
Marshall University	*Robert W. Coon*	
West Virginia University	*Richard A. DeVaul*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - April, 1984

WISCONSIN		
Medical College of Wisconsin	*Edward J. Lennon*	
University of Wisconsin	*Arnold L. Brown, Jr.*	
PUERTO RICO		
University of Puerto Rico	*Pedro J. Santiago Borrero*	
Ponce	*Enriquez A. Mendez, Jr.*	
LEBANON		
American University of Beirut	*Raja Khuri*	