1988-89 COD Administrative Board

*William T. Butler, Chairman
**L. Thompson Bowles, M.D., Ph.D., Chairman-Elect
George T. Bryan, M.D.
Phillip M. Forman, M.D.
David S. Greer, M.D.
John Naughton, M.D.
Leon E. Rosenberg, M.D.
Henry P. Russe, M.D.
Robert E. Tranquada, M.D.
Hibbard E. Williams, M.D.

* Chairman until 6/89
** Chairman as of 6/89

1988-89 AAMC Executive Committee

D. Kay Clawson, M.D., Chairman
David H. Cohen, Ph.D., Chairman-Elect
Robert G. Petersdorf, M.D., AAMC President
John W. Colloton, Immediate Past Chairman
William T. Butler, M.D.
Ernst R. Jaffe, M.D.
Gary Gambuti

AAMC ASSOCIATION OF AMERICAN MEDICAL COLLEGES

NEW DEANS' ORIENTATION

April 11-12, 1989

Fess Parker's Red Lion Resort
Santa Barbara, California

Tuesday - April 11

6:30 pm - 7:30 pm — Solstice

New Deans & Spouses Reception

Wednesday - April 12

8:00 am - 9:00 am — San Miguel/Santa Rosa

New Deans & Spouses Breakfast

9:00 am - 10:00 am — San Miguel/Santa Rosa

Welcome; AAMC Staff Introductions; and AAMC Program Descriptions

10:00 am - 12:00 pm — Santa Cruz

"Problem Sharing" Discussion

10:00 am - 12:00 pm — Anacapa

New Deans' Spouses Meeting

AAMC Staff

Robert G. Petersdorf, M.D., President
John F. Sherman, Ph.D., Executive Vice President
Richard M. Knapp, Ph.D., Senior Vice President
Thomas J. Kennedy, Jr., M.D., Associate Vice President
Kathleen S. Turner, Assistant Vice President
James D. Bentley, Ph.D., Vice President, Clinical Svcs.
Edwin Crocker, Vice President, Administrative Svcs.
Paul H. Jolly, Ph.D., Associate Vice President, Operational Studies
Donald G. Kassebaum, M.D., Associate Vice President, Institutional Planning and Development and Director, Section for Accreditation
Louis J. Kettel, M.D., Associate Vice President, Academic Affairs
Joseph A. Keyes, Jr., J.D., General Counsel and Vice President, Institutional Planning and Development
Thomas E. Malone, Ph.D., Vice President, Biomedical Research
Elizabeth M. Martin, Vice President, Communications
Herbert W. Nickens, M.D., M.A., Vice President, Minority Health, Disease Prevention and Health Promotion
August G. Swanson, M.D., Vice President, Academic Affairs

New Deans

(Appointed Since January, 1988)

Lester R. Bryant, M.D.
University of Missouri - Columbia

Wilton H. Bunch, M.D., Ph.D.
University of South Florida

Aram V. Chobanian, M.D.
Boston University

Jordan J. Cohen, M.D.
SUNY - Stony Brook

Rody P. Cox, M.D.
University of Texas Southwestern at Dallas

Robert D'Alessandri, M.D.
West Virginia University

James E. Dalen, M.D.
University of Arizona

Richard A. DeVaul, M.D.
Texas A&M University

Norman H. Edelman, M.D.
UMDNJ - Robert Wood Johnson

Charles H. Epps, Jr., M.D.
Howard University

Laurence Finberg, M.D.
SUNY - Brooklyn

Ronald D. Franks, M.D.
University of Minnesota - Duluth

Nancy E. Gary, M.D.
Albany Medical College

James A. Hallock, M.D.
East Carolina University

Samuel Hellman, M.D.
University of Chicago - Pritzker

Walter L. Henry, M.D.
University of California - Irvine

Edwin C. James, M.D.
University of North Dakota

Stephen R. Kaplan, M.D.
Wright State University

Charles McKown, M.D.
Marshall University

Herbert Pardes, M.D.
Columbia University

Martin L. Pernoll, M.D.
University of Kansas

Paul E. Stanton, Jr., M.D.
East Tennessee State University

Emery A. Wilson, M.D.
University of Kentucky

Saturday, April 15

SESSION VI

8:30 - 8:45 am - Sierra Madre

Discussion Topic Presentation
"ISSUES IN GRADUATE MEDICAL EDUCATION"
Karl P. Adler, M.D.
Dean, New York Medical College

8:45 - 10:15 am

SMALL GROUP DISCUSSIONS

10:15 - 10:45 am - Sierra Madre

COFFEE BREAK

SESSION VII

10:45 am - 12:15 pm - Sierra Madre

THIRD BUSINESS MEETING

ACTION PROPOSALS FROM
GROUP DISCUSSIONS

DISCUSSION OF
"STRATEGIC PLANNING FOR AAMC"
William T. Butler, M.D.

REPORT AND REQUEST FOR ACTION
ON ISSUES IN SCIENCE MISCONDUCT,
FRAUD AND CONFLICT OF INTEREST
Thomas E. Malone, Ph.D.
AAMC Vice President
Division of Biomedical Research

NEW BUSINESS

12:15 pm

ADJOURNMENT

PROGRAM PLANNING COMMITTEE

William T. Butler, M.D., Co-Chairman
L. Thompson Bowles, M.D., Ph.D., Co-Chairman
Karl P. Adler, M.D.
G. William Bates, M.D.
B. Lyn Behrens, M.B., B.S.
Joseph S. Gonnella, M.D.
Stanford A. Roman, Jr., M.D.

AAMC ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS SPRING MEETING

Program

April 12-15, 1989
Fess Parker's Red Lion Resort
Santa Barbara, California

COUNCIL OF DEANS
SPRING MEETING

April 12-15, 1989
Fess Parker's Red Lion Resort
Santa Barbara, California

Wednesday, April 12

7:30 - 10:00 am & 2:00 - 6:30 pm
Santa Barbara Ballroom Foyer
REGISTRATION

SESSION I

3:00 - 5:00 pm - Santa Ynez
FIRST BUSINESS MEETING

PRESIDING
William T. Butler, M.D.
Chairman, Council of Deans

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

PHYSICIAN SUPPLY TASK FORCE REPORT FOR ACTION
Daniel C. Tosteson, M.D.
Dean, Harvard Medical School

LEGISLATIVE UPDATE
Richard M. Knapp, Ph.D.
AAMC Senior Vice President

5:30 - 6:30 pm - Sierra Madre North
CHAIRMAN'S RECEPTION

Unscheduled Time

Thursday, April 13

SESSION II

8:30 - 8:45 am - Santa Ynez

REPORT ON AAMC ACTIONS TAKEN FOLLOWING THE 1988 COD SPRING MEETING
Louis J. Kettel, M.D.
AAMC Associate Vice President
Division of Academic Affairs

Discussion Topic Presentation
"ISSUES OF LOWER CLASS SIZE: THE IMPACT ON FUNDING, STUDENT RECRUITMENT, GRADUATE EDUCATION"
B. Lyn Behrens, M.D., B.S.
Dean, Loma Linda University
School of Medicine

9:00 - 10:30 am
SMALL GROUP DISCUSSIONS

10:30 - 11:00 am - Santa Ynez
COFFEE BREAK

SESSION III

11:00 - 11:30 am - Santa Ynez

Discussion Topic Presentation
"AAMC GOVERNANCE AND STRUCTURE"
William T. Butler, M.D.
Edward J. Stemmler, M.D.
University of Pennsylvania

11:30 am - 12:45 pm
SMALL GROUP DISCUSSIONS

Unscheduled Time

Friday, April 14

SESSION IV

8:30 - 8:45 am - Santa Ynez

Discussion Topic Presentation
"ISSUES IN HOSPITAL AFFILIATIONS"
John J. Hutton, Jr., M.D.
Dean, University of Cincinnati
College of Medicine

8:45 - 10:15 am
SMALL GROUP DISCUSSIONS

10:15 - 10:45 am - Santa Ynez
COFFEE BREAK

SESSION V

10:45 am - 12:30 pm - Santa Ynez
SECOND BUSINESS MEETING

REPORT ON THE SINGLE EXAMINATION FOR LICENSURE
L. Thompson Bowles, M.D., Ph.D.
Dean, George Washington University
School of Medicine

Robert L. Volle, Ph.D.
President
National Board of Medical Examiners

REPORT ON THE PROGRESS OF THE ASSESSMENT OF CHANGES IN MEDICAL EDUCATION (ACME): CHARLES E. CULPEPER FOUNDATION, INC. PROJECT
Louis J. Kettel, M.D.

Unscheduled Time

Association of American Medical Colleges

Council of Deans

1989 Spring Meeting

Fess Parker's Red Lion Resort

Santa Barbara, California

April 12-15, 1989

List of Participants

Deans

Karl P. Adler
Joan Burst Adler
New York Medical College

Henry H. Banks
Judith Banks
Tufts University

Harry N. Beaty
Georgia Beaty
Northwestern University
Medical School

B. Lyn Behrens
Dave Basaraba
Lomas Linda University
School of Medicine

Louis J. Bernard
Lois Bernard
Meharry Medical College

George M. Bernier
University of Pittsburgh
School of Medicine

Bryce O. Bliss
Jane Bliss
Oral Roberts University
School of Medicine

Stuart Bondurant
University of North Carolina
School of Medicine

L. Thompson Bowles
Judy Bowles
George Washington University
School of Medicine

Arnold L. Brown
Betty S. Brown
University of Wisconsin
Medical School

David M. Brown
University of Minnesota
Medical School - Minneapolis

George T. Bryan
Peggy Bryan
University of Texas
Medical School at Galveston

Lester R. Bryant
University of Missouri- Columbia

Gerard N. Burrow
Ann Burrow
UC - San Diego
School of Medicine

William T. Butler
Carol A. Butler
Baylor College of Medicine

John E. Chapman
Judy Jean Chapman
Vanderbilt University
Medical School

Richard A. Cooper
Andrea Cooper
Medical College of Wisconsin

Thomas S. Cottrell
Jane Cottrell
SUNY at Stony Brook Health
Sciences Ctr School of Medicine

Rody P. Cox
Jane Cox
University of Texas
Southwestern Medical Center

Robert D'Alessandri
Elaine D'Alessandri
West Virginia University
School of Medicine

Walter J. Daly
Indiana University
School of Medicine

Robert M. Daugherty
Sandra Daugherty
University of Nevada
School of Medicine

John M. Dennis
Mary Helen Dennis
University of Maryland
School of Medicine

John W. Eckstein
Jean Eckstein
University of Iowa College of Medicine

Charles H. Epps, Jr.
Howard University
College of Medicine

C. McCollister Evarts
Pennsylvania State University
College of Medicine

Ronald D. Franks
University of Minnesota
Duluth School of Medicine

Nancy E. Gary
Albany Medical College

Joseph S. Gonnella
Jefferson Medical College

David S. Greer
Marion Greer
Brown University
Program in Medicine

James A. Hallock
Jeanne Hallock
East Carolina University
School of Medicine

William K. Hamilton
Shyrlee Hamilton
UC - San Francisco
School of Medicine

James B. Hanshaw
Chris Hanshaw
University of Massachusetts
Medical School

Samuel Hellman
Marcia Hellman
University of Chicago
Pritzker School of Medicine

Walter L. Henry
UC - Irvine
College of Medicine

J. O'Neal Humphries
Mary Humphries
University of South Carolina
School of Medicine

John J. Hutton
University of Cincinnati
College of Medicine

Edwin C. James
University of North Dakota
School of Medicine

Robert J. Joynt
Margaret M. Joynt
University of Rochester
School of Medicine and Dentistry

Stephen R. Kaplan
Marilyn Kaplan
Wright State University
School of Medicine

John W. Kendall
Oregon Health Sciences University
School of Medicine

Donald R. Kmetz
Joan Kmetz
University of Louisville
School of Medicine

David Korn
Stanford University
School of Medicine

Walter F. Leavell
Vivian Leavell
Charles R. Drew University of
Medicine and Science

Richard G. Lester
Eastern Virginia Medical School

William H. Luginbuhl
University of Vermont
College of Medicine

Richard H. Moy
Caryl T. Moy
Southern Illinois University
School of Medicine

John Naughton
Margaret Naughton
SUNY-Buffalo School of
Medicine & Biomedical Sciences

Richard L. O'Brien
Joan O'Brien
Creighton University
School of Medicine

John C. Ribble
Anne Ribble
University of Texas
Medical School - Houston

Stanford A. Roman
Morehouse School of Medicine

Richard S. Ross
Elizabeth Ross
Johns Hopkins Medical School

Henry P. Russe
Pastora Russe
Rush Medical College of
Rush University

Kenneth I. Shine
UC - Los Angeles
UCLA School of Medicine

Eugene M. Sigman
University of Connecticut
School of Medicine

W. Douglas Skelton
Mercer University
School of Medicine

Frank G. Standaert
Joan Standaert
Medical College of Ohio

William Stoneman, III
Bette Stoneman
St. Louis University
School of Medicine

Alton I. Sutnick
Mona R. Sutnick
Medical College of Pennsylvania

Robert C. Talley
Katherine Talley
University of South Dakota
School of Medicine

James N. Thompson
Carol Thompson
The Bowman Gray
School of Medicine of
Wake Forest University

Daniel C. Tosteson
Harvard Medical School

Robert E. Tranquada
Janet Tranquada
University of Southern California
School of Medicine

Manuel Tzagournis
Ohio State University
College of Medicine

Robert H. Waldman
Jean Waldman
University of Nebraska
College of Medicine

Glenn Warnick
University of Utah
School of Medicine

Irwin M. Weiner
Liesolette Weiner
SUNY Health Science Center
at Syracuse College of Medicine

Michael Whitcomb
Gail Whitcomb
University of Washington
School of Medicine

Darryl M. Williams
Susan Williams
LSU - Shreveport
School of Medicine

Hibbard Williams
Sharon Williams
UC - Davis
School of Medicine

Emery A. Wilson
Clara Wilson
University of Kentucky
College of Medicine

I. Dodd Wilson
Ginger Wilson
University of Arkansas
College of Medicine

Harry Wollman
Anne Carolyn Wollman
Hahnemann University
School of Medicine

James J. Young
June Young
University of Texas Health Science
Center at San Antonio Medical School

Council of Deans
Distinguished Service Member

Edward J. Stemmler
University of Pennsylvania

Guests

Harry S. Jonas
American Medical Association

Robert L. Volle
National Board of Medical Examiners

AAMC Staff

James Bentley
Division of Clinical Services

Edwin L. Crocker
Denise Crocker
Division of Administrative Services

Debra Dabney
Division of Academic Affairs

Paul H. Jolly
Andrez Jolly
Section for Operational Studies

Donald G. Kassebaum
Division of Institutional Planning
and Development

Thomas J. Kennedy
Associate Vice President

Louis J. Kettel
Lois B. Kettel
Division of Academic Affairs

Joseph A. Keyes, Jr.
General Counsel and
Division of Institutional Planning
and Development

Richard M. Knapp
Senior Vice President

Thomas E. Malone
Division of Biomedical Research

Elizabeth M. Martin
Division of Communications

Herbert W. Nickens
Division of Minority Health, Disease
Prevention and Health Promotion

Gladys V. Peters
Rudolph R. Peters
Division of Academic Affairs

Robert G. Petersdorf
Patricia Q. Petersdorf
President

John F. Sherman
Deane Sherman
Executive Vice President

August G. Swanson
Division of Academic Affairs

AAMC Executive Committee

D. Kay Clawson
Janet Clawson
Chairman

Ernst R. Jaffe
Jane Jaffe

AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

March 3, 1989

Dear Colleague:

We hope that you plan to attend the Spring Meeting of the Council of Deans. While the Santa Barbara location is an ideal setting for a productive meeting, it also provides the perfect atmosphere for relaxation and getting to know one another. A special invitation is extended to spouses, as their participation is an important aspect of this meeting.

The meeting format will be similar to that of last year, promoting the sharing of ideas and experiences among Deans. Four of your colleagues will present opening remarks on timely subjects to be followed by group discussions. Recommendations for possible action by the Associations arising from the discussion groups will then be presented at the Business Session.

The Spring Meeting is <u>the</u> meeting where the format provides ample time for discussion of the important issues facing our schools. We are confident that you will find the interaction with your colleagues to be both challenging and rewarding.

New deans are particularly encouraged to attend. Special sessions will be held both for new deans and their spouses.

We look forward to seeing you in Santa Barbara.

With personal regards,

William T. Butler

William T. Butler, M.D.
Chair

L. Thompson Bowles

L. Thompson Bowles, M.D. Ph.D.
Chair-Elect

COUNCIL OF DEANS
1989 SPRING MEETING PROGRAM

April 11-15, 1989
Fess Parker's Red Lion Resort
Santa Barbara, California

Program Committee

William T. Butler, M.D., Co-Chair
L. Thompson Bowles, M.D., Ph.D., Co-Chair
Karl P. Adler, M.D.
G. William Bates, M.D.
B. Lyn Behrens, M.B., B.S.
Joseph S. Gonnella, M.D.
Stanford A. Roman, Jr., M.D.

TUESDAY - APRIL 11, 1989

5:00 p.m. - 7:30 p.m. - Santa Barbara Ballroom Foyer

REGISTRATION

6:30 p.m. - 7:30 p.m. - San Rafael

New Deans & Spouses Reception with COD Administrative Board, Program Committee, Executive Committee, AAMC Staff and Spouses

7:30 p.m. - UNSCHEDULED TIME

WEDNESDAY - APRIL 12, 1989

7:30 a.m. - 10:00 a.m. - Santa Barbara Ballroom Foyer

REGISTRATION

8:00 a.m. - 9:00 a.m.

New Deans & Spouses Breakfast with COD Administrative Board, Program Committee, Executive Committee, AAMC Staff and Spouses

9:00 a.m. - 10:00 a.m.

Welcome
William T. Butler, M.D.
Council of Deans Chair

AAMC Staff Introduction
Robert G. Petersdorf, M.D.
AAMC President

AAMC Program Descriptions
AAMC Staff

WEDNESDAY - APRIL 12, 1989 (Cont'd)

10:00 a.m. - 12:00 p.m.

New Deans/Admin Board/AAMC Staff Discussion Group

"Problem Sharing"
William T. Butler, M.D.

12:00 p.m. - UNSCHEDULED TIME

12:30 p.m. - 2:00 p.m.

Private Free-standing Medical Schools Council of Deans Luncheon

2:00 p.m. - 6:30 p.m. - Santa Barbara Ballroom Foyer

REGISTRATION

SESSION I

3:00 p.m. - 5:00 p.m. - Santa Ynez

FIRST BUSINESS MEETING

Presiding
William T. Butler, M.D.

AAMC President's Report
Robert G. Petersdorf, M.D.

Physician Supply Task Force Report for Action
Daniel C. Tosteson, M.D.
Dean, Harvard Medical School

Legislative Update
Richard M. Knapp, Ph.D.
AAMC Senior Vice President

5:30 p.m. - 6:30 p.m. - San Rafael

Chairman's Reception

6:30 p.m. - UNSCHEDULED TIME

THURSDAY - APRIL 13, 1989

7:00 a.m. - 8:15 a.m.

Pennsylvania Medical Schools Council of Deans Breakfast

7:00 a.m. - 8:15 a.m.

Western Medical Schools Council of Deans Breakfast

THURSDAY - APRIL 13, 1989 (Cont'd)

7:00 a.m. - 8:15 a.m.

Southern Medical Schools Council of Deans Breakfast

SESSION II

8:30 a.m. - 8:45 a.m. - San Ynez

"Report on AAMC Actions Taken Following the 1988 Spring Meeting"
Louis J. Kettel, M.D.
AAMC Associate Vice President
Division of Academic Affairs

8:45 a.m. - 9:00 a.m. - San Ynez

"Student Recruitment, Issues of Lower Class Size:
The Impact on Funding"
B. Lyn Behrens, M.B., B.S.
Dean, Loma Linda University School of Medicine

9:00 a.m. - 10:30 a.m.

SMALL GROUP DISCUSSIONS

10:30 a.m. - 11:00 a.m. - Santa Ynez

Coffee Break

SESSION III

11:00 a.m. - 11:15 a.m. - Santa Ynez

"AAMC Governance and Structure"
William T. Butler, M.D.

11:15 a.m. - 12:30 p.m.

SMALL GROUP DISCUSSIONS

12:30 p.m. - UNSCHEDULED TIME

1:00 p.m. - 2:30 p.m.

Community Based Medical Schools Council of Deans Luncheon

4:00 p.m. - 5:00 p.m.

Nominating Committee Meeting

6:00 p.m. - 11:00 p.m.

RECEPTION/DINNER

About Small Group Discussions: Leaders will be assigned from the COD Administrative Board. Each group of participants (10-15) will be assigned from the attendees.

FRIDAY - APRIL 14, 1989

7:00 a.m. - 8:15 a.m.

Texas Medical Schools Council of Deans Breakfast

7:00 a.m. - 8:15 a.m.

University of California Medical Schools Council of Deans Breakfast

7:00 a.m. - 8:15 a.m.

Midwest-Great Plains Medical Schools Council of Deans Breakfast

SESSION IV

8:30 a.m. - 8:45 a.m. - Santa Ynez

"Issues in Hospital Affiliations"
John J. Hutton, Jr., M.D.
Dean, University of Cincinnati College of Medicine

8:45 a.m. - 10:15 a.m.

SMALL GROUP DISCUSSIONS

10:15 a.m. - 10:45 a.m. - Santa Ynez

Coffee Break

SESSION V

10:45 a.m. - 12:30 p.m. - Santa Ynez

SECOND BUSINESS MEETING

Report on the Single Examination for Licensure

L. Thompson Bowles, M.D., Ph.D.
Dean, George Washington University School of Medicine
&
Robert L. Volle, Ph.D.
President, National Board of Medical Examiners

Report on the Progress of the Assessment
of Changes in Medical Education (ACME):
Charles E. Culpeper Foundation, Inc. Project
Louis J. Kettel, M.D.

12:30 p.m. - UNSCHEDULED TIME

12:30 p.m. - 1:45 p.m.

COD Administrative Board Luncheon

SATURDAY - APRIL 15, 1989

7:00 a.m. - 8:15 a.m.

California Medical Schools Council of Deans Breakfast

SESSION VI

8:30 a.m. - 8:45 a.m. - Santa Ynez

"Issues in Graduate Medical Education"
Karl P. Adler, M.D.
Dean, New York Medical College

8:45 a.m. - 10:15 a.m.

SMALL GROUP DISCUSSIONS

10:15 a.m. - 10:45 a.m. - Santa Ynez

Coffee Break

SESSION VII

10:45 a.m. - 12:15 p.m. - Sierra Madre

THIRD BUSINESS MEETING

Action Proposals from the Discussion Groups

Discussion of "Strategic Planning for the AAMC"
William T. Butler, M.D.

Report and Request for Action on Issues
in Science Misconduct, Fraud and Conflict of Interest
Thomas E. Malone, Ph.D.
AAMC Vice President
Division of Biomedical Research

NEW BUSINESS

12:15 p.m.

ADJOURNMENT

MEETING FACTS

LOCATION/TRANSPORTATION

Year-round resort hotel on 24 acres overlooking the ocean. 1 mile from Stearn's Wharf. 1-1/2 miles from Santa Barbara courthouse and El Paseo. 10 miles, 15 minutes from Santa Barbara Municipal Airport serving commercial and private aircraft with a lighted asphalt runway 6,000 feet long; **complimentary shuttle**. 1-1/2 miles from Santa Barbara railroad station; **complimentary shuttle**. Hotel is located on Cabrillo Blvd., 1 block southwest of the intersection of Hwy. 101 and Milpas St. You may wish to have a rental car in order to explore the community and local countryside.

ACCOMMODATIONS

All rooms have air conditioning, direct-dial phone, remote control color TV, radio, electric clock and refrigerator. Suites have wet bar.

DINING/ENTERTAINMENT

Maxi's Dinning Room offers haute cuisine 5-11 p.m. with entrees $15-35. Maxi's Lounge is open 5 p.m.-1:30 a.m. for entertainment and dancing. Cafe Los Arcos features an informal oceanview setting and is open 6:30 a.m.-11:30 p.m. with entrees $7-18. Bar Los Arcos located off the lobby serves cocktails and snacks. Room service available.

SERVICE/FACILITIES/SHOPS

Hair salon and gift shop. Car rental and local tour desks. Ice and vending machines. Laundry and dry cleaning. Free parking for registered guests.

RECREATION/AMUSEMENT FACILITIES

Heated Junior Olympic outdoor swimming pool and Jacuzzi therapy pool. Across the street from white sand beach, windsurfing and volleyball courts. One mile to pier for boating, sailing and deep sea fishing. Fitness facility with sauna. 3 lighted tennis courts. Bicycle rentals, croquet, badminton, putting green and shuffleboard. Hotel can arrange for golf at several scenic nearby courses.

CLIMATE

Average temperature for the Santa Barbara area: summer (April-September) max. 72, min. 56; winter (October-March) max. 66, min. 47. Average annual rainfall is 18 inches. **Air quality**

HOTEL RESERVATIONS

Fess Parker's Red Lion Resort, 6333 East Cabrillo Blvd., Santa Barbara, California. Reservations must be made by March 11, 1989.

ACCOMMODATIONS	RATES
Single(s) 1 person	$130.00
Double(s) 2 persons - 1 bed	$130.00
Double(s) 2 persons - 2 beds	$130.00

Suites available upon request.

AIRLINE RESERVATIONS

Discounts are available through American Airlines to cover any combination of travel dates, April 9 - 18, 1989. When making travel plans, call **1-800-433-1790** and refer to **Star #96114.**

American Airlines Meeting/Incentive Agreement

1. To make available Meeting Saver Fares equal to 5% off any published AA fare, with all restrictions applying. Tickets must be purchased seven (7) days in advance based on "M" class availability and is valid to Santa Barbara (LA Complex) from various points within the contiguous 48 states for travel as indicated:

   Meeting dates: April 11-15, 1989
   Travel dates: April 9-18, 1989

   Passengers are subjected to a $30 service fee when applying for a full or partial refund once tickets are issued. Should a lower American promotional fare be available, the Meeting Services Desk will confirm the lowest American fare, providing normal qualifications are met.

2. Use of American's Meeting Service Desk 800 number (1-800-433-1790) is required for making individual flight reservations, as special discounts are only available through this facility.

MEETING REGISTRATION

Please tear out and complete the meeting registration form and return by **March 24, 1989** to:

Gladys V. Peters
Association of American Medical Colleges
One Dupont Circle
Suite 200
Washington, D.C. 20036

AAMC FUTURE MEETING DATES

1989

February 22-23	Executive Council/COD Admin. Board Washington, D.C.
April 11-16	COD Spring Meeting Fess Parker's Red Lion Resort Santa Barbara, California
June 14-15	Executive Council/COD Admin. Board Washington, D.C.
September 27-28	Executive Council/COD Admin. Board Washington, D.C.
October 27-Nov. 2	AAMC Annual Meeting Washington, D.C.
December 13-15	Officers Retreat Wye Woods Conference Center

1990

February 21-22	Executive Council/COD Admin. Board Washington, D.C.
April 7-11	COD Spring Meeting Sonesta Sanibel Harbour Resort Florida
June 27-28	Executive Council/COD Admin. Board Washington, D.C.
September 26-27	Executive Council/COD Admin. Board Washington, D.C.

AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

COUNCIL OF DEANS 1989 SPRING MEETING
Fess Parker's Red Lion Resort
Santa Barbara, California
April 12-15, 1989

Documents for
Business Meetings and Small Group Discussions

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

Chicago Marriott Hotel
Chicago, Illinois

Monday, November 14, 1988

2:00 P.M. - 5:00 P.M.

I. CALL TO ORDER AND QUORUM CALL

William T. Butler, M.D., Chair, declared a quorum and called the meeting to order at 2:00 p.m.

II. APPROVAL OF THE MINUTES

The minutes of the Council of Deans Spring Business Meeting of March 23, 1988, Hilton Head, South Carolina were approved.

III. REPORT OF THE PRESIDENT

Dr. Butler, introducing President Robert G. Petersdorf, M.D., expressed the gratitude of the Administrative Board and the Council for his leadership this year.

Dr. Petersdorf reported as follows:

- Annual Report

  The status of the Association, its major activities and the new graphics identity are highlighted and well described in the report.

- Recruitment

  Herbert M. Nickens, M.D., has been appointed Vice President for Minority Health, Disease Prevention and Health Promotion. The Association's Executive Staff recruitment is now complete.

  Of the 12 staff members, six have been at the Association for 12 years or more and six have joined the staff since Dr. Petersdorf arrival two years ago...a useful mix of institutional memory and long term constituent relationships, combined with people bringing new ideas and experiences to the Association.

o Strategic Planning

During the past six months the Executive Staff developed a formal strategic plan for the Association. This included development of a new Mission Statement approved by the Executive Council, June 1988, and a set of seven strategic goals debated by each of the Administrative Boards. The plan itself is a subject for discussion at the December Officers Retreat.

o Outside Support

A priority of Dr. Petersdorf's during the past year has been to increase the level of outside support for AAMC programs. Both the Macy and Robert Wood Johnson Foundations have made awards to support expanded activities and minority participation in medical education. These are initiatives of the new Division of Minority Health, Disease Prevention and Health Promotion.

The Charles E. Culpeper Foundation will support an in depth examination of curriculum changes in North American medical schools. The medical education mission is central to academic medicine. The Culpeper program is the first major educational study since the GPEP Report. It will be directed by Dr. Kettel in the Division of Academic Affairs.

o Academic Medicine

The new AAMC Journal will appear in January, be handsome, interesting, lively and wide ranging in scope.

o School Visit Program

Thank you for your support of the school visit program. It is very useful for AAMC staff to meet you on your own turf so you have an opportunity to demonstrate unique and interesting aspects of your schools.

This year, we visited Minnesota, New Jersey (Newark), Loma Linda, Rochester, Creighton, Nebraska, Jefferson and within the next month the Medical College of Ohio and Northeast Ohio. Our intention is to visit each medical school on a four year cycle.

o NRMP

John S. `Jack` Graettinger, M.D., Executive Vice President of NRMP, has announced his retirement. The AAMC under

an agreement with NRMP will the manage and administrate the match after this coming year. For now NRMP will remain in Evanston. Eventually it will move to the Division of Student Services in Washington.

o Applicant Pool

First year enrollment is up 42 places from last year. Now 20 weeks into the application cycle for 1989, there is a less than three percent decline in the number of applicants compared to last year.

o Task Forces and Committees

The AAMC's Committee on AIDS at the Academic Medical Center is about to complete its work. The Report on Policy Guidelines for Addressing HIV Infection In The Academic Medical Community was mailed just before this meeting and received very complimentary remarks from Surgeon General Koop.

The MCAT Review Committee will conclude this year also. The Task Force on Physician Supply will present a progress report tomorrow. A new Committee on The Effect of the Nursing Shortage on Teaching Hospital Activities and an ad hoc Committee to Examine AAMC Governance and Structure are just beginning their work. The Nursing Committee is specifically oriented to nursing services, not the issue of nursing supply or nursing education.

Documents on ethical behavior by researchers and institutional policies to deal with misconduct and an analytical paper on trends in hospital profits, with particular emphasis on recent teaching hospital data are being prepared. We will be working on issues raised by the HSIA Study on Physician Reimbursement.

o Telephone Log Study

A telephone log study was done by the Division of Academic Affairs in September, 1988. Of the 319 telephone calls reported, the average length of time in handling the inquiries was 20 minutes. Twenty-six calls related to the declining applicant pool, 19 from residents who wanted to consolidate their loans -- and 18 were related to proposals about a six year curriculum.

Other issues included questions about substance abuse by medical students, offshore medical schools and curricula. We were asked how medical schools are dealing with computer use, finances, medical literature, geriatrics, research, ethics, legal matters, humanities, nutrition,

acupuncture and emergency medicine,.

Some unusual comments were received on the decline in NBME scores and a combined chiropractic and allopathic degree to maximize earning potential. There were fascinating questions about the MCAT.

IV. **REPORT OF THE CHAIR**

Dr. Butler thanked Dr. Kettel for his activities at AAMC, then announced the appointment of the Spring Meeting Planning Committee: Drs. L. Thompson Bowles, Joseph F. Gonnella, B. Lyn Behrins, G. William Bates, Stanford A. Roman and Karl P. Adler. Anticipating their meeting tomorrow, he invited the Council to submit any special topics for consideration. Finally he noted that the largest attendance (150) we have had at a deans' dinner is set for tonight at the Art Institute.

Dr. Butler introduced the new deans to the Council. They are: Wilton H. Bunch, M.D., Ph.D., University of South Florida; Aram V. Chobanian, M.D., Boston University; Jordan J. Cohen, M.D., SUNY Stony Brook; Rody P. Cox, M.D., Texas Southwestern; James E. Dalen, M.D., University of Arizona; Norman H. Edelman, M.D., New Jersey (R.W.J.); Charles H. Epps, Jr., M.D., Howard; Ronald D. Franks, M.D., University of Minnesota (Duluth); James A. Hallock, M.D., East Carolina; Samuel Hellman, M.D., University of Chicago; Steven R. Kaplan, M.D., Wright State; Emery A. Wilson, M.D., University of Kentucky; Martin L. Pernoll, M.D., University of Kansas; and Nancy E. Gary, M.D., Albany.

V. **NOMINATING COMMITTEE REPORT**

Dr. Alton I. Sutnick reported the Committee composed of Drs. Harry N. Beaty, Peter O. Kohler, Kenneth I. Shine, and Eugene M. Sigman. The COD Nominating Committee met during the COD Spring Meeting in Hilton Head, March 21, 1988 and by conference call on August 10, 1988. The Committee proposed the following slate:

CHAIR-ELECT OF THE COUNCIL OF DEANS

L. Thompson Bowles, M.D., Ph.D.
Acting Vice President for Medical Affairs and
Dean for Academic Affairs
George Washington University Medical Center

MEMBERS-AT-LARGE OF THE COUNCIL OF DEANS

David S. Greer, M.D.
Dean and Professor of Community Health
Brown University
Program in Medicine

Leon E. Rosenberg, M.D.
Dean and CNH Long Professor of Human Genetics
Yale University School of Medicine

Hibbard E. Williams, M.D.
Dean and Professor of Internal Medicine
University of California - Davis
School of Medicine

COUNCIL OF DEANS REPRESENTATIVES TO THE EXECUTIVE COUNCIL

George T. Bryan, M.D.
Vice President for Academic Affairs and Dean
University of Texas
Medical School at Galveston

Phillip M. Forman, M.D.
Vice Chancellor for Health Services and Dean
University of Illinois
College of Medicine

W. Donald Weston, M.D. *
Dean
Michigan State University
College of Human Medicine

* To complete two years of Dr. Bowles' unexpired term as a representative to the Executive Council.

VI. DISCUSSION ITEMS

A. Single Examination For Licensure

Dr. Bowles described the history of concern about a dual pathway to licensure. These concerns have legal, ethical and equity bases. The states of New York and California have specifically indicated dissatisfaction with a dual pathway to licensure. There was an effort toward a single examination by the Federation of State Medical Boards and the National Board of Medical Examiners 7-8 years ago. Little progress was made toward that goal, however.

For the past year, several organizations have revisited the question. Those organizations were the AAMC, the National Board of Medical Examiners, the Educational Council on Foreign Medical Graduates, the Federation of State Medical Boards, the American Medical Association, the ACGME, the Department of Health and Human Services -- and on several occasions, the American Osteopathic Association.

The principal goal was the improvement of medical care in the United States of America through a proper licensing structure. The model for the single examination that evolved is a three part examination, using part one of the National Board of Medical Examiners as the first step; part two, roughly in its current form, as the second step and a FLEX examination that would combine some of the features of the current FLEX One and Two as the final step.

Some concerns have emerged in the course of the discussions surrounding this model. Would such an examination process open to all applicants, regardless of which medical school they attended or from which they graduated have a negative effect on the LCME accreditation process in the United States? The protection lies in the fact that the licensing jurisdictions and the ACGME still require graduation from an LCME accredited school or the Certificate from the ECFMG.

If there were a single examination for licensure, would that per force become an overpowering influence on the medical education program of our 127 medical schools? Any licensing examination system drives the curriculum. This is a concern that will have to be monitored very carefully if a single examination pathway were to come to pass.

Will there be an assessment of clinical skills? The proposal assumes that at least students from non LCME accredited schools would need to pass a clinical skills evaluation prior to full participation in this examination sequence. Exactly when and exactly how is to be determined. The problems attendant to developing satisfactory clinical skills assessment examinations are large. It cannot be assured that such an examination will be available at the time the single examination for licensure is implemented.

What of the NBME certification? The present certificate would have to be modified. It is possible to continue an NBME certification to be used for other purposes than licensure.

What would be the impact of failure to pass this single examination? It is important that all of us organize an educational program that would insure a virtual 100 percent our graduates are capable of passing through the entire system. This is particularly important in light of the Part One performance on this June, 1988 sitting of the NBME test.

Dr. Kettel said the two other Task Force AAMC representatives were Drs. Donald G. Kassenbaum and William H. Luginbuhl. Conceptually, the Task Force agreed from the start to limit the proposal to licensing, not accreditation and other issues, and to look at the mechanics of licensure and be sure a

single examination could be designed. At this stage the draft has been sent for comment to the LCME, the ACGME, and the NBME. The Task Force will meet again in December. If there are no major changes, it would go to the NBME Board of Directors early in 1989. If they endorse and support it, the proposal would move to AAMC Councils, the AMA and other organizations to gain support. There is no rigid time frame.

Dr. Edward Stemmler emphasized the need to preserve the role of the National Board of Medical Examiners. He emphasized the assurance of quality provided by requiring graduation from an LCME accredited school in order to obtain NBME certification. He noted the loss of the LCME requirement already since some states do not require that as exclusively. There is the allowance of using ECFMG certification in lieu of LCME accreditation in the proposal, but Dr. Stemmler asked the body to consider the value to the academic community of preserving the role of a voluntary private sector body i.e., NBME. The NBME has in its history always defined what it viewed as the quality standard that should be used as the basis for licensure -- and that's the debate.

Dr. Marjorie Wilson, President of the Educational Council of Foreign Medical Graduates, stated that the ECFMG was pleased to be included in the group that developed the working paper. The ECFMG certificate represents an evaluation of readiness for graduate medical education in this country in the best way that we can do it thus far.

On another issue, this past year the ECFMG has been discussing with the National Board of Medical Examiners the possibility of providing Part I and Part II of the NBME examinations as an option to the FMGEM examination. The option may be offered for the first time in September of 1989.

ECFMG is not a licensing body; however, in almost every licensing jurisdiction, there is the requirement of either passing the FMGEM's examination or having the full ECFMG certificate in order to sit for the FLEX examination.

Dr. Richard Moy stated his hope that the new version of the NBME examination would be more positive in driving the curriculum in the future.

Dr. Bowles responded that he thought it would be a better examination.

B. <u>NBME Committee on Clinical Skills Assessment</u>

Dr. George Miller, NBME Steering Committee on Clinical Skills Assessment, described the kind of program being developed over the next five years. Historically, the NBME has been interested in clinical skills assessment since the first

examination in 1916 -- a five day examination. Two segments of that exam were set aside for the assessment of clinical skills. Gradually, there was discontent with that methodology. In about 1958, when as part of the new three Part examination, the clinical skills were shifted to Part III. However, that form of part III was less an evaluation of clinical skills than a bedside assessment of the disease which the patient represented. Because of this a new Part III examination committee was established. A central feature of that effort was the critical incident study which still is a standard point of reference for the delineation of the elements of clinical competence.

Then came NBME's introduction of three new elements of the clinical skills assessment: 1) the film examination, 2) program examination and 3) a more standardized bedside examination -- all of which in subsequent years have disappeared as sophistication in the psychometric analysis of the examinations revealed increasingly that these had a low level of reliability.

In 1973, the Committee on Goals and Priorities again pointed to the importance of delineating and examining the elements of clinical competence. The Blue Ribbon Committee recommendations led to changes in Parts I and II and a report that noted it was essential to move ahead with the assessment of clinical skills.

The recent committee, appointed two years ago, with a detailed review of the literature. This review pointed to some central questions that needed to be answered in ordered to develop a systematic assessment of clinical skill of sufficient reliability and validity to be incorporated in the evaluation procedure part of the NBME objectives. These studies, research and development are to be accomplished in time to include this as a part of the NBME examination sequence sometime in the mid 90's.

The research and development will be carried out by collaborative efforts with individual schools. The studies will be designed to answer questions about feasibility, logistics, psychometrics, etc. Hopefully, the activity will serve as an impetus to the development of a refined method of assessing the clinical skills not only of our medical school students and graduates, but conceivably, those at other levels of medical education, as well.

C. Medical School Applicant Pool

Dr. August Swanson, Vice President for Academic Affairs, referred to the distributed material. The 1988 data as for mid October shows 26,720 applicants. The number of acceptances produced 15,969 new entrants, 42 more than 1987. There continues to be a downturn in applicants, steeper for men than for women -- 29 percent decrease for men and 18 percent for women from '84 to

'88.

The final totals for applicants to the 1988 entering class will soon be complete. It is anticipated that there will be a few more applicants this year than last year. The composition of the applicant pool for the under-represented minorities shows a decrease of 19 percent between '84 - '88. For the white applicant pool, a decrease of 32 percent, and for the Asian and Pacific Islander applicant pool, an increase of 17 percent.

The entering 1988 class was slightly larger than 1987 but the overall change from 1981, the year of the largest number of applicants in U.S. history, with an entering class of 16,660, is down to 15,969 -- a minus 4 percent change.

The female matriculant pool continues to rise. There are 37 percent female matriculants this year. There has been almost no change in the under-represented minority group since 1981. There is a decrease of 14 percent in white matriculants, and an increase of 61 percent in Asian Pacific Islanders.

The west remains the region with the highest number of applicants for positions available. Only 57 percent of the western region applicants are admitted while 63 percent are admitted from the central region pool. The overall acceptances nationally was 60 percent this year. That compares with 46 percent admitted in 1981.

The MCAT scores for 1984, in biology, chemistry and physics scores averaged 10, for 1988, 9.5. The overall GPA for matriculants for 1984 was 3.55 for 1988 was 3.51.

D. Graduating Student Questionnaire

Dr. Swanson continued. The transition between medical school and residency has been an issue since 1986. As a result of the ad hoc Committee chaired by Spencer Foremann, M.D. an addendum to the Graduation Student Questionnaire (GSQ) investigated the GME selection process. The data on the classes of 1986 and 1987 provide a base line. The '88 class was the first to experience 1) the influence of the change in the release date of deans' letters to November 1, 2) the change in the schedule of the NRMP, moved from the first week in January to mid February and 3) the effect of the discussion between medical schools, program directors and teaching hospitals.

The GSQ reveals slightly later career choice dates than in 1986. Programs have moved application deadlines later in the year. There have been changes criteria for selection. Possibly related to a letter from Robert Volle, Ph.D., President of the NBME on the limitations of using board scores in the selection process. Candidates report being asked less to provide their board scores.

The percentages of programs requesting students to do audition electives has not changed as much as hoped. Orthopedic surgery still had nearly 85 percent of the candidates reporting that one or more programs requested they do an audition elective, neurosurgery 76 percent and neurology 67 percent. Asking students to make a commitment before the match actually occurs has been a common problem, but varies by specialty. Psychiatry in the last two years has worked hard on the problem and produced a remarkable change, from 53 percent of candidates reporting they were asked to do a pre-match commitment in 1987 to 14 percent in 1988. The GSQ is a useful database. I urge you to work with your student affairs deans to try to improve the response rate.

The program directors Forum On The Transition From Medical School To Residency met for the third time this year. The attitude is toward mutual problem solving. There is a good chance to smooth this transition from medical school to graduate medical education, even further.

Dr. Leon Rosenberg asked if the members of residency programs functioning outside the match is increasing? If so, what is the way to address it? Is this a growing problem, is it a significant problem in particular specialty areas? I am particularly concerned about anesthesiology.

Dr. Swanson stated that it is the opposite. Some specialties still use an early, private match. I am trying to talk them into abandoning them and moving into the NRMP. Anesthesiology is new to the NRMP match. It takes about five years to get everyone into a matching program. They are probably at about two-thirds to three-quarter mark right now.

Dr. Swanson was asked to comment on the concerns of program directors in internal medicine. First, the later time of completing the match list works to some disadvantage for northern schools where travel is difficult in the winter months. Second, the length of the interviewing season is long.

Dr. Swanson said the problems of winter should not be sufficient to prompt switching time schedules. The length of time now available was good so schools could have more time to watch students during their fourth year, more time to develop deans letters and more time for assessment by the programs. The armed forces programs seem willing to use the NRMP albeit they'll not be using the actual NRMP schedule yet.

Dr. Kettel commented that following a request by Dr. Frank M. James, the Anesthesia Programs not participating in the match were identified. He called the deans of the department heads involved. There was general enthusiasm to participate.

E. "Traffic Rules" for the Admission to Medical School

Dr. Robert Beran described the Group on Student Affairs Committee on Admissions review of admissions especially the timing of the issuing of acceptances and the selection among multiple acceptances by applicants...the so-called Traffic Rules.

There are nine understandings that appear as the newly recommended traffic rules to become operational this year. The two most significant items relate to specific dates. The first is March 15th, the time by which an institution is to have issued a sufficient number of acceptances to fill the first year entering class. This is already the date most schools use, but it has not been specified.

The controversial date is May 15th. The rule asks students holding multiple acceptances to choose the school they want by May 15th. This date may be difficult for obtaining financial aid because the availability of data regarding financial aid cannot be provided to the applicant. Without such data applicants may not be able to choose the school. It would help if sometime over the course of the next month each school's admissions officer and financial aid officer could meet to plan their strategies for this year and to prepare for next year when the date moves to April 15. The whole intent to the traffic rules is to move that process earlier.

The rest of the traffic rules haven't changed. New emphasis is on the size of the acceptance deposit. The recommendation on the books for years has been $100 but about 40 percent of the schools have larger acceptance deposits. Once the traffic rules dates are functional the acceptance deposit becomes moot.

Responding to a question, Dr. Beran noted that a national medical student matching program was on the agenda of the GSA Admissions Committee. A pilot attempt may be tried by the California schools. Richard Ranlett at the AAMC has offered to work with other states. The state of Ohio has different circumstances than California. It would be nice to compare processes.

Dr. Beran then reported on the release date for Dean's letters - November 1. Only about 35 letters have been sent to AAMC by student affairs deans indicating materials to obtain Deans letters before November 1 requested of students earlier. There is still pressure being placed on some students because of interview dates. If a program severely limits the time available for interviews, it also limits the students latitude. AAMC will survey students again this year and report on the problems there.

F. Report of the Ad Hoc Committee on the Dean's Letter

Dr. Joseph Gonnella noted that the Dean's letter of recommendation reflects on the credibility of faculty, has an impact on students' use of the first part of their senior year and impacts the way program directors use NBME scores. The 11 member committee wishes to convince deans that the letters should be directed to recapturing the credibility of the faculty.

The committee discussed three basic questions. First, is the Dean's letter to recommend based upon selected information and documents a conclusion or is it a thorough evaluation of the student's progress over the first three and a half years of medical school? And as corollaries, does the letter chronologically document with specific objective information the professional growth of the students? The committee favored the latter position and even recommended calling it the Dean's Letter of Evaluation. Second, should information be given in the letter that relates the students' performance to the school's students in general? The committee recommends that some peer data be included in the letter. Third, should there be a uniform format all deans follow? The committee without trying to dictate a cookbook format, favored uniformity.

Dr. Harry Beaty asked if there could be leeway in allowing the school to decide how much emphasis they want to put on the pre-clinical courses? Dr. Gonnella responded that those basic science courses which allow observation in the laboratory can provide equally good information on behavior as occurs in student's the clinical clerkships.

Dr. George Bryan asked what program directors look at? Dr. Gonnella noted that program directors were looking for facts. The committee stressed the word "evaluation" rather than recommendation. Dr. Kettel noted that several published studies rank the audited elective very high, then the recommendations of the Chairs of departments in the discipline, then colleagues at the institution recommendations then NBME scores and finally, the Dean's Letter. Analyzing these items, it isn't that the Dean's Letter is unimportant, but rather, it doesn't have any additional "useful" information. The program directors at the Forum stated they want the Dean's Letter information in any form provided.

G. Charles E. Culpeper Foundation Proposal to "Assess the State of Curricular Revisions in U.S. Medical Schools in Response to the Changing Care Environment and In Light of New Educational Initiatives"

Dr. Kettel described the three year grant to study the status of curricula in the United States. The project being funded at almost a million dollars follows from the observations that the GPEP and other recommendations have been available long enough to

have prompted change in curricula, but the "word in the land" is little is happening. This project will quantitate the state of change. It will study why change does and doesn't occur. The study is designed to make some new or revised recommendations and then to implement changes through workshops, consultations, sabbaticals and whatever it takes to
change in each situations. Dr. Harry Beaty will chair the Advisory Group to guide the Association 's conduct of the study.

Dr. John Kendall described the Culpeper funded project to change curriculum at Oregon. The first thing is to look at the process for change. Attention then goes to problem like educating students in life long love of learning. Then changes in teaching methodology will be considered.

H. Faculty Participation in Public Education About Animals in Research

Dr. Robert Tranquada described the continuing and developing crisis in the use of animals in research. Specifically, pound laws are being changed to close access to research purchases. There is increasing regulation. The Animal Liberation Front continues its activities. The antivivisectionists are taking over the humane societies along with their generous endowments. As much as $30 million a year is spent on this issue by the opposing groups. New coalitions are being formed between the antivivisectionists and environmental groups. Stanford and the University of California in San Francisco and Berkeley have been attacked resulting in the expenditure of millions of dollars in unjustified environmental studies, lawsuits and a variety of other tactics of delay and increased cost of construction for research buildings. The People for Ethical Treatment of Animals (PETA) have brought suit in California to gain standing in the consideration of all new research buildings in the state. Vice President Lawrence Horton of Stanford in writing for a presentation at Berkeley. said:

"For the most part, I do not think the scientific and university communities have faced up to the seriousness of the political problem posed by the opponents of research with animals.

"And let me state that rather bluntly -- the dominant organizations and spokespersons active on animal issues seek fundamental change in laws and regulations governing the use of animals in research, and those changes wold shut down much of biomedical research as we know it. Many openly desire outright abolition of research with animals and are avowedly true antivivisectionists. But the most political astute realize that the same objective can effectively be accomplished by restricting the supply of animals, adding unnecessary regulatory incumberances and raising the cost of research to an unacceptable level.

"Part of the failure to face the nature of the problem I believe is that most informed people recognize that antivivisection and some level of activism on animal issues has been a staple item in society and politics for well over the past century -- certainly during the lifetime of anyone living now. Consequently, there is a pervasive belief that societal forces will prevent any serious damage to research. There will be an automatic correction that will dampen the current activism, and soon all will be restored to a situation in which antivivisection remains, but harmless at a low level constant the way it is remembered.

"I believe this view is only half right. The continuities between the antivivisection in the past and present are far greater than any discontinuities. It is after all, the same basic themes, same arguments, even remarkably similar rhetoric.

"The half that is wrong is the notion that some benign spirit or good-hearted social force, whatever that is, will step in to prevent any serious political damage. The reason previous political attempts to enact an antivivisectionist agenda failed are precisely because the scientific community and its friends organized and fought the matter politically.

"It is all too easy to assume that contemporary activism is different or more potent than in the past and that it was easier to be politically effective then than it is now. I doubt that seriously, and when one reads about the extraordinary political battles at the turn of the century -- one of which had President Elliott of Harvard and his faculty appear en masse before the Massachusetts General Court to plead the cause of research -- I think one can draw the opposite conclusion. Our predecessors had a rougher time defending fledgling experimental science than we ought to have today in defending contemporary science.

"There is therefore, no benign social force that will save the day; the countervailing force to the increasingly active and effective animal activist lobby will be the scientific community and it supporters. Particularly the beneficiaries of research, if there is to be a countervailing force.

"And without a countervailing force, I believe it is certain there will be more restrictive, costly and unnecessary legislation. Any individual bill may have a plausible -- but not compelling reason for passage and may have a limited impact, but collectively, a body of such legislation will I believe, blunt science and research."

Dr. Tranquado continued stating that the AAMC as an organization is involved with the National Foundation for Biomedical Research; individual states have their organizations.

I think however, that it is incumbent upon deans as leaders in our academic communities to convey the urgency of this matter to our faculties. The California group put together last summer a draft of a letter which is in the agenda. I recommend two things:

One, that each dean consider ways to underline and emphasize this very serious problem to faculty; and particularly the research community within faculties. The letter in your agenda book is a model.

Two, the item could be referred to the COD Ad Board for additional specific recommendations.

Suggestions from the floor included: enhancing the visibility of Assistant Secretary Robert Windom's statement about animal research and inviting Surgeon General Koop to make a statement on animals and research. A joint invitation with the AMA might be particularly strong to Dr. Koop. Another suggestion to the Ad Board is to collect data on problems and solutions as they develop around the country. Then figure out a way to share the collective experience and wisdom. Another commenter suggested thoughtful articles such as Ruth Bulger's Anatomical Record need emphasis. Here the intellectual reason for research using animals is reviewed.

Dr. William Stoneman noted the resolution that was adopted by the House of Delegates of the AMA at Interim 1987 came from the medical school deans. The resolution suggested we approach the public through the practicing physicians' involvement in a public information campaign among his own patients concerning the importance of research -- because they are ultimately the real beneficiaries.

Dr. Tranquada reminded the Council of recent public polls indicating that 75-80 percent of the public supports the humane use of animals in biomedical research. This favorable support will decrease if we don't build and reinforce it.

Chair Butler reported that on Saturday afternoon, the AAMC Executive Committee met with the Chairs of the Association's Groups; i.e., groups on student affairs, business affairs, public affairs and so forth. In discussion with the Group of Public Affairs, animals was one of the key areas for developing procedures and policies to bring a broader awareness on a public basis. At each school you can work with public affairs officers and bring all ideas forward.

Dr. Richard Moy, based on an Illinois legislator's suggestion reminded the Council that hearings are a good place for a grateful parent or a grateful patient not a research professor to comment.

Ms. Dunn spoke to separating the use of animals in biomedical research from medical education. The OSR position has been to encourage alternative models for teaching and instructing. She urged that the autonomy of the student and the choice of participation in such things as dog labs be maintained.

Dr. Tranquada noted that he was very careful not to include education, just biomedical research.

Another speaker suggested that the Veterans Administration Secretary be asked to take a stand. In addition, the science advisor of the President could be an important advocate in developing policy.

Dr. John Sherman said one hopeful sign is the NIH December 7th conference with the National Foundation for Biomedical Research. They have invited representatives of voluntary health groups to discuss the use of animals in research and the importance of the objectives of those voluntary health groups. It is hoped they will mobilize the grassroots potential of the organizations. He proposed cooperation with those groups as they try to implement their individual strategies.

Dr. Sutnick recalled Ann Landers was an AAMC plenary session speaker. She might be helpful in identifying, other sympathetic journalists and columnists in the general public approach.

Chair Butler agreed that Ann Landers has been very supportive of animals in research. We owe her a debt of gratitude. If she happened to take the other position, she could be very damaging.

Another speaker suggested that faculty join local Humane Societies and another felt the leadership of the National Rifle Association, concerned about this issue for hunting, might be an ally.

Chair Butler pointed out that this is a subject each one realizes is extraordinarily serious. It will be high on the visibility list. Keep us informed if you have any particular problems that come up and need prompt attention. Also, communicate with others.

J. Student Loan Default Committee

Dr. Beran described a study of student loan defaults. The default information occurs mostly in the news media. It is not medicine specifically. This study will try to obtain medical graduate specific information. The Association will take a pro-active stance on this, but have facts with regards to student loan

defaults.

K. AAMC Strategic Goals

Dr. Beaty noted that the mission statement fails to identify some of the key activities of the Association. These include information gathering, integration, coordination and communication. The second sentence would better follow the third.

Dr. Donald Weston stated that some consideration might be given to "warming" the language a bit. The strategic goal, although reasonably well stated, leaves out some of the things that respond to human values. Are the relevant behavioral sciences included in the term "biomedical knowledge?" It could be more explicit.

L. Veterans Administration Budget Issues

The Veterans Administration has been elevated to Cabinet status. The chief medical director, Secretary of the VA, and 8 or 10 Assistant Secretaries become Presidential appointments. The political process could override the search committee selection process for a chief medical director which guarantees that the names the President picks from are acceptable to the broad constituency of the VA. I am pleased to say that the search committee process has been codified in the law.

The VA does has serious budget problems. Dr. Beaty testified on behalf of the AAMC illustrating the serious problems at the Lakeside Medical Center (Chicago). The House Veterans Affairs Committee looked at the staffing patterns of VA hospitals. Although by law the hospitals have a specified bed level, they were in reality not being maintained at that level of staffing, primarily because of inadequate funding. Despite the fact that the original inadequate funding occurred at the Office of Management and Budget under the direction of the Office of the President -- it is also true that when this become known, additional funds were not requested or supplied during the past year. To compound the problem, Congress passed enabling legislation for more program entitlements without adding funds.

Dr. Butler asked that deans use Harry Beaty's testimony; Dr. Leon Rosenberg's letter to members of the House Veterans Affairs Committee, and Senator Cranston's letter requesting additional supplemental funds as resource materials during the holiday Congressional recess to work with legislators in bringing forth the importance of the VA affiliation and particularly the importance of increasing the funding for the VA.

From the floor the Chair was asked whether a task force involving veterans groups and Congressional people might help to make sure that a major supplementary bill does not fall through the cracks? Also will the present administrator be carried over in the new administration, i.e. will he be one of the people carried over? Will the new administration appoint a new administrator/Secretary?

Dr. Butler said he had no information on General Turnage's plans. Dr. John Gronvalls' position is secure. He has a four year appointment, has completed two years, and since he is not yet a Presidential appointee, he does not have to submit his resignation. The VA budget issue will be brought to the AAMC New Officers Retreat.

M. Report of Ad Hoc Committee to Review the Nomination Process

Dr. Kettel noted the silence of the bylaws on the process of obtaining nominations. Past Nominating Committee have varied in the way they collect names. Dr. Butler asked the immediate past Chairs of Nominating Committees to meet via conference call during the summer. Based on 5 years' experience, they recommended to the Ad Board some process suggestions which were accepted in September, 1988. Thus, the instructions to the Nominating Committee for this coming year are:

1. Conduct an annual poll, submit names not assigning particular officers. Identify people you think would be capable of serving anywhere in the Association. This gives the Nominating Committee some freedom to place nominees where they think you fit best in accordance with Association rules.

2. AAMC staff will obtain resumes and/or curricula vitae on all nominees.

3. The Nominating Committee will meet in person not by conference call.

4. The details of who can serve and who has served in the past will be provided to the Nominating Committee.

5. Geographic distribution and ethnic balance will be assured by the Nominating Committee.

6. Election will not be by mail ballot.

VII. **INTRODUCTIONS OF DISTINGUISHED SERVICE MEMBERS, EMERITUS MEMBERS AND GUESTS**

Dr. Butler recognized:

Distinguished Service Members

Stanley Olson, M.D.
Edward Brandt, M.D., Ph.D.

Emeritus Members

DeWitt Baldwin, M.D.

Guests

Harry Jonas, M.D.
Carlos Martini, M.D.
Ira Singer, M.D.
Kaye Clawson, M.D.
Thomas Bruce, M.D.
Marjorie Wilson, M.D.

Dr. Butler notes that the AMA Section on Medical Schools and the Administrative Board of the Council of Deans have attempted to interchange information on a regular basis. Dr. William Stoneman, Chair of the Section , invited him to attend the Governing Council Meeting and in return, he invited Dr. Stoneman to join the Administrative Board meeting today.

VIII. **OSR REPORT**

Ms. Kimberly Dunn thanked Dr. Butler and the Council of Deans Administrative Board for their help this year. She also expressed appreciation to the Association staff, particularly Wendy Pechacek, LaVerne Tibbs, Sarah Carr Gretchen Chumley and Drs. Kettel, Beran, Swanson and Mitchell. She then thanked the GSA and GME steering committees, and Dr. John C. Ribble, dean, University of Texas at Houston.

Ms. Dunn described the OSR retreat; the OSR orientation handbook; an OSR resource handbook; Strategies to use the graduation questionnaire and the OSR LCME workshops.

Clayton Ballantine's OSR survey to determine school use of the graduation questionnaire, and other curricular and student affairs activities were described. The past OSR Chair and a second year resident in OBGYN, Vicki Darrow, M.D. met with about 52 residents. This group recommends to the Association resident participation mainly concerning education. They suggested calling the group CORE -- the Committee on Resident Education.

Finally, although this is the "year of the student," Ms. Dunn said we need to think more broadly to the decade of the patient. The last few days OSR spent a great deal of time talking about the issues related to the interface of medicine and the public interest. Ms. Dunn then reported on the OSR task force headed by Joe Kruton, a Baylor College 4th year student. The purpose is to collect and disseminate information intended to educate students on the various activities and possibilities in the care of all patients.

Clayton Ballantine, 4th year student, University of Louisville, incoming Chair, introduced himself. He introduced the new chair-elect from Emory University, Caroline Reich. The other member of the OSR administrative board are: from the southern region, Kathleen Hubb, University of South Florida; from the western region, Sheila Ragge, UCLA; from the central region, Joan Legin, University of Chicago; from the northwestern region, Beth Melco, University of Connecticut. At-large-members are: Lawrence Simm, University of Kansas; David Costa, Tulane; Lee Rosen, Baylor; Cindy Knutsen, University of Colorado; and Anita Jackson, University of Illinois.

IX. OLD BUSINESS

None

X. NEW BUSINESS

Dr. Butler recognized Dr. Robert Talley who suggested that across the board $32,500 dues for medical schools was inappropriate. The argument has been given that all schools receive the same service and all generate the same expenses; however, schools are quite different. Faculty size ranges from 2,839 to 43, student size form 2,668 to 131, research federal dollars from $85 million to zero. Practice income also varies widely.

Thus, total revenue ranges from 467.2 million to 4.4 million dollars. The $32,500 dues per medical school as a percent of that revenue has the Association's least rich school paying 0.7 percent of its revenue, while the richest pays just 0.007 percent. Suppose the richest school were to pay .7 percent of their budget -- their dues would be $3,352,608.00 !

Dr. Talley then described an alternative scaled strategy for billing. He also noted that asking small schools to bear the same burden as larger schools risks, that those smaller schools may find it not worthwhile to belong to the Association.

Dr. Butler thanked Dr. Talley and recalled that this concern was taken to the Executive Council. The Executive Council recommended the dues which will be voted on at the Assembly this afternoon. Each can express their position at that time. Dr. Talley was asked to submit the proposal in writing, so that it could be examined critically.

Dr. Leonard Napolitano raised an issue brought from the Council of Academic Societies. The National Institutes of Health Division of Research Resources was statutorily created to deal with biomedical research technology at general clinical research centers, biomedical research boards, primate centers, minority biomedical research and funding for AIDS infrastructure. On October 31, the Advisory Committee was informed that a study is being conducted to consider modifying the role and responsibility of the Division. The medical schools have some input through two deans who serve on the Council, i.e., Stuart Bonderant and Dr. Napolitano. Dr. Bonderant's term is now up. Hopefully he will be reappointed, once they can figure out what the Division of Research Resources is going to do at NIH. At the present time, research support services of NIH, i.e., the Intramural Research Support Services are being fused into the Division of Research Resources, but the future is not clear. I think it is important for schools of medicine and the Offices of Dean to watch what is happening.

Dr. Butler commented that Robert Friedlander, M.D. and Richard Ross, M.D. completed their terms on the Ad Board. In addition he noted that Will Deal, M.D., resigned his deanship to become President of Maine Medical Center. He added his appreciation to all three for the service they gave.

There being no other business, the meeting was adjourned.

"Student Recruitment, Issues of Lower Class Size: The Impact on Funding"

DISCUSSION DOCUMENTS WILL BE HANDED OUT
AT THE SPRING MEETING

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

CHARGE TO THE COMMITTEE ON GOVERNANCE AND STRUCTURE

In 1965, the Association of American Medical Colleges received the report "Planning for Medical Progress Through Education." The report, known as the Coggeshall Report after its chairman Lowell Coggeshall, a past president of the AAMC, spoke broadly on issues of medical education and trends in health care. As a result of the committee's perception of the evolving health care environment, major changes in the Association's governance were proposed. The debate within the Association on the recommendations of the report led to a tripartite organization of the Council of Deans, the Council of Teaching Hospitals, and the Council of Academic Societies. The Executive Council was expanded to include faculty and teaching hospital executives as well as medical school deans. In 1971, medical students were added to the Association's governance through the Organization of Student Representatives.

It has now been two decades since the last comprehensive review of the Association's governance. The Association's Executive Council recently adopted a new mission statement for the organization and new strategic goals are also being developed. Thus, the Association's elected leadership believes it is prudent to consider whether the current structure best meets the Association's needs and objectives or whether changes in the constituency and the organization suggest modifications.

The Committee on Governance and Structure has been established by action of the Executive Committee and is charged with reviewing the current governance structure of the Association with particular attention to the following issues: *

- o the membership on each of the Association's three Councils
- ● the participation in the Association by individuals at academic medical centers who are not currently represented on any of the Association's Councils, including, but not limited to vice-presidents for health affairs
- o the role of multi-hospital systems and their executives in the Association
- o the role and composition of the Assembly
- ● the composition of the Executive Council

* Issues of special importance to the COD are solid bullets.

(Over)

- the nominating process by which new officers are elected to the Executive Council and Administrative Boards

- the name of the Association and whether it accurately reflects the organization's membership and purposes

- the role in the Association beyond election to distinguished service or emeritus membership for individuals who no longer serve on one of the three Councils

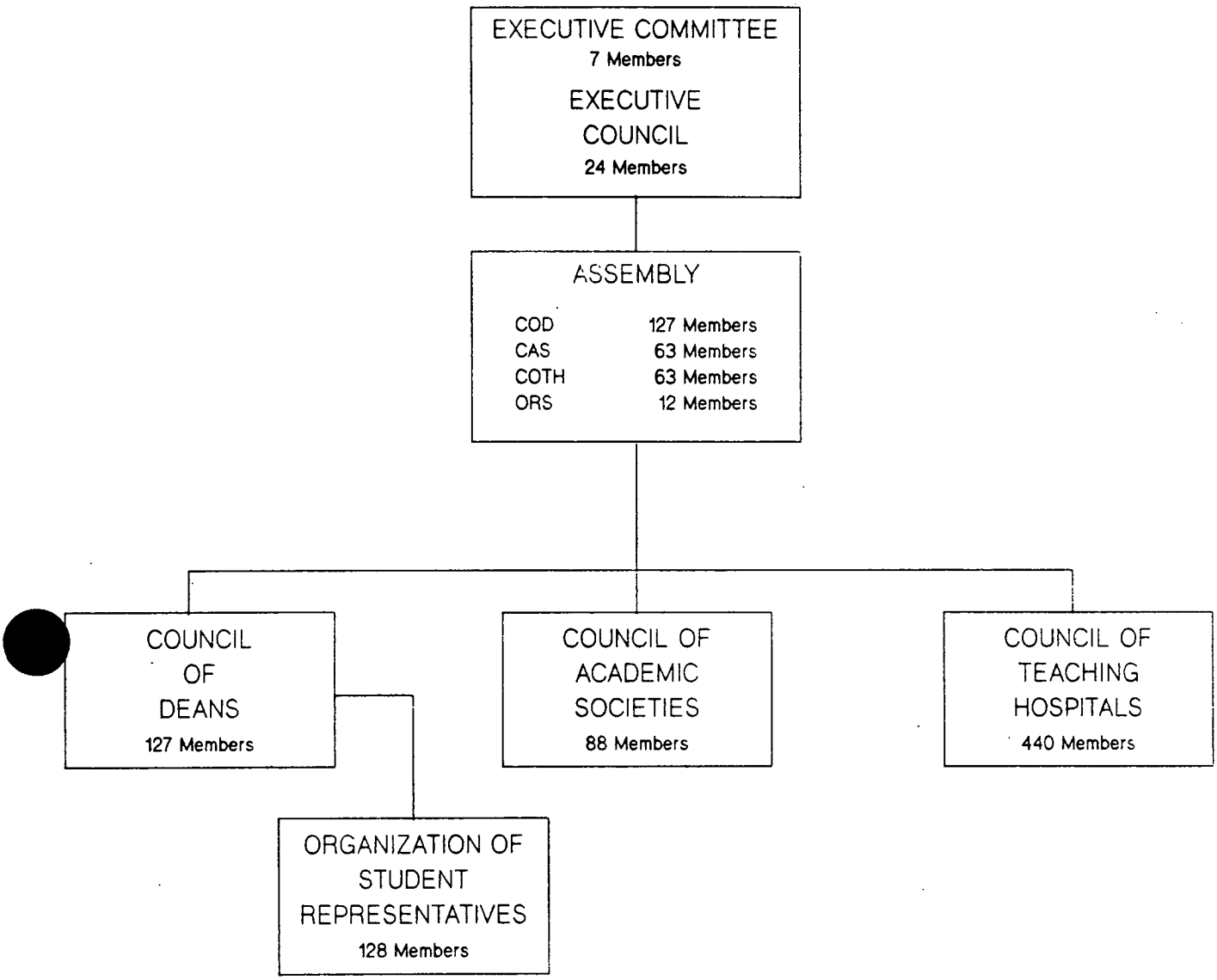
- the fostering of a greater sense of identification with and participation in the Association by members of the Councils and by faculty and administrators of academic medical centers

- the role of housestaff in the Association

- the means through which the Association might involve individuals with specific institutional educational responsibilities such as hospital directors of medical education or directors of continuing medical education

- the Association's existing and possible new Groups and their contributions to the Association's goals

Association of American Medical Colleges
Governing Structure



Executive Committee:

Chairman: *D. Kay Clawson, M.D., University of Kansas School of Medicine*
Chairman-Elect: *David H. Cohen, Ph.D., Northwestern University Graduate School*
Immediate Past Chairman: *John W. Colloton, University of Iowa Hospitals & Clinics*
Chairman, COD: *William T. Butler, M.D., Baylor College of Medicine*
Chairman, CAS: *Ernst R. Jaffe, M.D., Albert Einstein College of Medicine*
Chairman, COTH: *Gary Gambuti, St. Luke's–Roosevelt Hospital Center*
President: *Robert G. Petersdorf, M.D.*

12/88

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #88-56

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals
Organization of Student Representatives

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: Officers of the Association & Councils - 1988-89

Following is a list of the AAMC Executive Council members, and officers of the Council of Deans, Council of Academic Societies, Council of Teaching Hospitals, and Organization of Student Representatives for 1988-89:

EXECUTIVE COUNCIL *Executive Committee Members

Chairman: D. Kay Clawson, M.D.*
University of Kansas

Chairman-Elect: David H. Cohen, Ph.D.*
Northwestern University

President: Robert G. Petersdorf, M.D.*

Immediate Past Chairman, AAMC:
John W. Colloton*
U of Iowa Hospitals & Clinics

Representatives:

COD: L. Thompson Bowles, M.D., Ph.D.*[1]
George Washington University

George T. Bryan, M.D.
U of Texas-Galveston

William T. Butler, M.D.*[2]
Baylor College of Medicine

Phillip M. Forman, M.D.
University of Illinois

John Naughton, M.D.
University at Buffalo, SUNY

Henry P. Russe, M.D.
Rush Medical College

Robert E. Tranquada, M.D.
U of Southern California

W. Donald Weston, M.D.
Michigan State University

CAS: S. Craighead Alexander, M.D.
University of Wisconsin

Joe Dan Coulter, Ph.D.
University of Iowa

Ernst R. Jaffe, M.D.*
Albert Einstein

Douglas E. Kelly, Ph.D.
U of Southern California

COTH: J. Robert Buchanan, M.D.
Mass General Hospital

Gary Gambuti*
St. Luke's-Roosevelt Hosp. Cntr.

James J. Mongan, M.D.
Truman Medical Center

Raymond G. Schultze, M.D.
UCLA

*[1]as of 6/89
*[2]until 6/89

"ISSUES IN HOSPITAL AFFILIATIONS"

Discussion Questions

1. What do community hospitals and colleges of medicine typically need and hope to gain by affiliating with one another? What trade-offs are usually made to achieve mutual gains?

2. What costs of medical education should hospitals and colleges of medicine bear, respectively, and how are these costs to be calculated? Conversely, what should a major affiliate expect to pay the college for affiliation of residencies, programs, etc.?

3. How should service chiefs and residency directors in affiliated hospitals be appointed, evaluated, and reappointed? What are the advantages and disadvantages of service chiefs and residency directors being the same person? What authorities should they have, and how should they relate to the college of medicine departmental chair?

4. University hospitals and major affiliates frequently compete for patients, clinical programs, etc. How is competition managed, especially when third party payors are restricting lists of hospitals where their members can be treated?

5. Physicians practicing in various affiliates have various degrees of commitment to the parent university hospital and faculty practice plans. How should "taxes" on clinical income paid to the department and the college be established for these physicians?

February 20, 1989

Dear : (Same letter sent to CEO's of affiliated hospitals)

In followup of the last meeting of the Interinstitutional Steering Committee, I decided to list more specifically some of the goals I would like to accomplish with regard to our major hospital affiliations. I suggest you discuss this letter with members of your senior administrative and medical staff. Our concerns are primarily with the assigning and teaching of medical students and residents in affiliated programs. We are not concerned with governance of free-standing residencies per se, but we are concerned with the assignment of students to free-standing programs. A basic distinction should be made between the environment necessary to educate the third year medical students in core clerkships (Medicine, General Surgery, Obstetrics/Gynecology, Psychiatry, Pediatrics) and fourth year junior internships (Medicine, Pediatrics) versus the less rigid environment that is necessary when teaching students who are on specialty electives. The following comments apply to teaching hospitals that offer the core clerkships. Major commitments to close supervision and teaching are necessary.

A major teaching affiliation requires multi-year contracts that clearly specify the relationships between the College and the hospital. It is important to have joint College/hospital committees to facilitate problem solving and to monitor compliance with the contract. Our goal is to have at least five joint hospital/College services in a major affiliate with jointly appointed service chiefs and integrated residencies. This must include Medicine and General Surgery, plus as many as possible of services with major student contact such as Obstetrics/Gynecology, Psychiatry, Emergency Medicine, Pathology, Radiology, etc. Only if the College and the hospital have multiple departments involved in the relationship can the College of Medicine through the Dean exert sufficient control to prevent the kinds of fighting that has recently occurred at the departmental level between staff at the College and the affiliate. In order for the hospital and the College to relate to one another institutionally, it is necessary to have enough vested interests to warrant intervention by senior administration when there are problems.

More specifically, I would list some of our goals as:

1. To provide appropriate types of clinical experiences for medical students. We will work to assure that the major teaching hospitals have a full complement of students and residents in their programs in order to accomplish this aim and to have a sufficient "density of education" to create a favorable environment.

2. To provide adequate basic science and clinical resources to meet increasingly stringent academic standards for accreditation of residencies. Participation of College of Medicine research and basic science faculty in postgraduate education is frequently the key to maintenance of full accreditation of residencies.

3. To assure that the College of Medicine can provide direct academic and clinical supervision of medical students by assigning major required core clerkships (third year clerkships and fourth year junior internships) only to hospitals with integrated residencies (wherever possible) and significant numbers of faculty. The medical school will educate its undergraduate students where its influence on graduate medical education is strongest.

4. To develop long term contractual relationships that specify mutual expectations of the College and hospital and include formal mechanisms of conflict resolution. Needs for affiliations are often identified at the departmental level and a substantial responsibility for the effective operation of affiliations rests with the medical school department head and the hospital service chief. However, successful affiliations require the support of the senior administrative officials and governing bodies of the College and hospital.

5. To agree that the College (particularly the directors of the relevant clinical departments) and the hospital have a joint voice in the appointment and monitoring of performance of the hospital service chiefs and residency directors. Service chiefs in a major teaching hospital will be recognized as senior faculty with multi-year terms of appointment and will, after appropriate joint review, be eligible for reappointment in a manner similar to review and reappointment of departmental directors in the College. Service chiefs will be responsible to the hospital Chief Executive Officer for hospital operations (which will be administered autonomously of the College) and to the Director of the relevant department of the College for education.

6. To restrict College of Medicine faculty appointments to individuals who perform significant teaching in College programs. This will enhance recognition and reward of individuals who contribute to the programs of the College, particularly in major teaching hospitals.

7. To establish a basis for cooperation in the development of clinical programs. Partnerships in health care delivery may flow naturally from major College/hospital affiliations.

8. To develop a better public understanding of the commitments to programs that uniquely characterize major teaching hospitals.

I am sharing some of my thoughts with you in order to stimulate discussion at the Interinstitutional Steering Committee. It is highly probable that some hospitals will want relatively close relationships with the College of Medicine and others will want a much more distant relationship with lesser involvement in medical education. It seems likely that the umbrella agreement will contain a general outline of principles, but that it will be necessary to negotiate much more detailed agreements with some of the key hospitals.

Perhaps it is reassuring to point out that these general principles govern the relationship between the College and Children's Hospital. This affiliation has been in place for many years and works in the best interests of both institutions. It is also similar to agreements in place between teaching hospitals and medical schools in other parts of the country.

I look forward to additional discussions with you and the medical staff.

Sincerely yours,

John J. Hutton, M.D.
Dean, College of Medicine

JJH/gh/3199n

cc: Associate Deans
Clinical Department Directors
Dr. Donald Harrison
Mr. David Fine
Dr. Clifford Grulee, Jr.

PRELIMINARY ROUGH DRAFT OF RECOMMENDED MODIFICATIONS
OF THE AFFILIATED HOSPITAL'S AGREEMENT
JANUARY 20, 1989

I. This Master Affiliated Hospital's Agreement made and entered into this _____ day of _____ 1989 by and among the University of Cincinnati on behalf of the College of Medicine (hereinafter "University" "College" respectively) and _____[1]_____, _____[2]_____, _____[3]_____, _____[4]_____, and _____[5]_____, (hereinafter individually "Bethesda", "Christ," "Good Samaritan," "Jewish," and "Children's" respectively and collectively "Affiliated Hospitals"). [Note one through five need to be completed using the legal names of these hospitals.]

I. WHEREAS, Affiliated Hospitals will play a major role in the educational programs of the University of Cincinnati College of Medicine; are nonprofit corporations providing quality medical care and each: (1) accepts the desirability of participation in integrated residency programs as defined by the Accreditation Council on Graduate Medical Education (hereinafter ACGME), or (2) accepts third year medical students for core clerkships and junior internships in the clinical disciplines of Internal Medicine, General Surgery, Obstetrics and Gynecology, Psychiatry and Pediatrics; (3) or accepts fourth year students for electives or other educational assignments, and (4) has affiliated residencies that meet ACGME requirements and are covered by a formal agreement with the College; and

WHEREAS, the College of Medicine and the Affiliated Hospitals recognize the potential value of collaborating for the benefit of patient care in the community, and the enhancement of the highest quality medical education; consider it a privilege to participate in educational programs; and

WHEREAS, it is established that residents play a crucial role in the education of medical students, and the Affiliated Hospitals understand that the College of Medicine will only assign medical students for core clerkships and junior internships where the residency is fully approved by the ACGME and has not been placed on probation by a Residency Review Committee of the ACGME and both the College and the Affiliated institution plan to work toward an increasingly close relationship in which the development of integrated residencies will be encouraged whenever possible, and

WHEREAS, the Affiliated Hospitals accept the primacy of the educational needs of medical students as assigned by the University of Cincinnati College of Medicine, understand that such assignments must relate to the effectiveness of the teaching at any site and, therefore will be adjusted accordingly, and further, will not impose other individual preceptorships upon college programs for students from schools other than the University of Cincinnati.

NOW THEREFORE, for and in consideration of the following mutual convenants, terms and conditions, the College and the aforementioned Affiliated Hospitals mutually agree as follows:

II. Objectives. The College and the Affiliated Hospitals acknowledge the following common objectives which may be furthered by the agreement:

A. To improve the quality and delivery of patient care;

B. To encourage the development and/or execution of training programs at the medical graduate and medical undergraduate levels;

C. To provide an environment for the development of excellence in educational programs;

D. To enhance the community's and the College of Medicine's ability to attract and retain young well trained practitioners;

E. To provide a broad based subject population for medical research which has been approved by the respective Institutional Review Boards.

III. Corporate Relationships.

A. The College and the Affiliated Hospitals further acknowledge that this agreement is designed to provide a structural basis for specific educational programs to be developed departmentally within the College and between the College and the Affiliated Hospitals. Each residency program shall be covered by a separate subsidiary agreement, each of which shall be approved by the College. In the case of integrated residency programs, the (e.g. ACGME) requirements of such programs will be specifically covered in the subsidiary agreement.

The terms of this Agreement shall apply to and be incorporated within each subsidiary agreement; no term of this Agreement may be superceded by a conflicting or alternative term in any separate subsidiary agreement except by an express reference that the parties intend for the conflicting or alternative term in the separate subsidiary agreement to take precedence.

B. Inter Institutional Steering Committee.

1) There shall be an Interinstitutional Steering Committee on which individual members shall have one (1) vote (for a total of _____ votes for the entire committee).

2) The membership of this Committee shall be the Dean of the College and the person from his/her staff who has responsibility for Affiliated Hospital relationships; the Chief Executive Officer of each Affiliated Hospital and the member of his/her staff who has delegated responsibility for relations with the College in educational and research programs; and two (2) at large, full-time faculty members of the College, serving at the pleasure of the Dean.

3) The Interinstitutional Steering Committee shall be responsible for the following:

a. Considering all matters affecting this agreement between the College and the Affiliated Hospitals and making recommendations to the appropriate parties concerning such matters.

b. Assuring that, at the departmental level, the coordinator of medical students and residency education in each clinical discipline at an Affiliated Hospital together with his/her counterpart(s) in the College department, under the chairmanship of the director of that department (or his/her designee) meet at least quarterly to support the coordinated operation of the educational programs.

c. Providing oversight of the accreditation status of residency programs, the continual availability and functioning of a formerly designated teaching faculty with appropriate faculty appointments, a teaching/conference program approved by the director of the parent department of the College, and the appropriate supervision of student clinical activities such as the receipt and evaluation by faculty at the Affiliated Hospitals of formal presentations and write-ups and the assignment of residents and faculty teams specifically designated for teaching.

d. Annually reviewing the relationship expressed by this Agreement and recommending changes.

e. Annually compiling standardized data regarding medical education, both undergraduate and graduate, and occurring both within the College and within the Affiliated Hospitals.

C. Each Affiliated Hospital and the College shall appoint one or more Intra-Hospital (or University) committees for medical education. This (these) committee(s) shall be responsible for the following:

1. Coordinating the development and implementation of all residency programs in accordance with ACGME and the respective Specialty Board policies, through representative membership from each Affiliated Hospital on the Council on Graduate Medical Education of the University of Cincinnati Medical Center.

2. Coordinating the development and implementation of undergraduate medical (clinical training) programs and ensuring that these are linked to and coordinated with residency programs that currently meet ACGME and Specialty Board standards (preferably integrated residency programs).

3. At the departmental level assuring that the coordinator(s) of medical student and residency education in each clinical discipline at each Affiliated Hospital is/are made available to meet at least quarterly with counterpart(s) in the College department to support coordinated operation of the educational programs under the chairmanship of the director of that department (or his/her designee).

4. Assuring that the Affiliated Hospitals and the College agree to accept only students from the College into core clerkships and junior internships and not to change the number of students being trained without prior approval of the College.

5. Acting as an appropriate liaison between such Intra-Hospital or University Committee(s) for Medical Education and the individuals within each Affiliated Hospital or the College who are responsible for managing medical education.

6. Reporting any pertinent information regarding all medical education activities, including credentials of all residents in affiliated programs, in a timely manner to the Interinstitutional Steering Committee.

7. Providing the Interinstitutional Steering Committee with an annual report based on a standardized data format to be provided by the College of Medicine which accommodates to the needs of each particular resident and student program with input from the individual departments of the College, their counterparts in the affiliated institutions, the Office of Students Affairs and the Office of House Staff Affairs.

IV. Operating relationships.

A. Patient and teaching programs:

Patients under the care of the medical staff of the Affiliated Hospitals will be included in the teaching programs unless the patient objects. Each Affiliated Hospital will solicit the cooperation of its medical staff and patients toward this end. It is contemplated that the educational programs developed among the parties will involve both hospitalized patients and ambulatory patients.

B. Service programs and clerkship directors:

1. All clinical service, residency program and/or clerkship directors in Affiliated Hospitals will be appointed for renewable three year terms. They will be recommended for appropriate non-tenured appointments by the relevant departmental director of the College and be approved by the Dean. Residency directors will be appointed in accordance with the regulations of the ACGME. Every effort will be made by the College and the affected Affiliated Hospital to reach consensus on these appointments. In the case of either clinical service or residency program directors, if the College departmental director and the Chief Executive Officer (hereinafter CEO) of the Affiliated Hospital(s) or their designees cannot achieve consensus, then a Search Committee of not more than six (6) individuals will be appointed to be composed of three (3) persons from the College and three

(3) from the Affiliated Hospital. The CEO of the Affiliated Hospitals will appoint three (3) members of the Search Committee and retain responsibility for the appointment, provided however that no final appointment will be made without the consensus of the Dean of the College. Likewise the Dean of the College will appoint three (3) members of the Search Committee and will be consulted by the CEO of the Affiliated Hospital before final appointment is consummated. The CEO of the Affiliated Hospital and the Dean shall be coequals and co-chairpersons of the committee to approve the director, who cannot be appointed without the concurrence of both. The relevant clinical department director in the College will be responsible for approving and recommending faculty appointment at appropriate rank. Further, he/she will be responsible for selection and appointments of all teaching staff in his/her discipline in any college program. In the case of integrated residency programs, the special (e.g. ACGME, etc.) requirements of such programs will be specifically covered in the subsidiary agreement.

2. The stipends of this/these individuals will be paid by the Affiliated Hospital(s), in and amount negotiated by the director of the parent department and the CEO of the Affiliated Hospital and approved by the Dean.

3. The performance of residency program and clerkship directors will be evaluated annually by the appropriate director of the parent department of the College. This evaluation will be in

in writing, and copies will be sent to the residency/clerkship director, the Dean, and the CEO of the Affiliated Hospital. The department director may reappoint or terminate the residency/clerkship director at the end of a three year term of appointment after notification of the Dean and Affiliated Hospital CEO. Termination before completion of a three year term requires the concurrence of the Dean and the Affiliated Hospital CEO.

It is agreed that existing program directors in Affiliated Hospitals and their staffs who have faculty appointments in the College meet the aforementioned conditions unless it is determined at the time of the signing of this Agreement, or subsequently, that they have failed to carry out their responsibilities in regard to teaching or other assigned activities as stated in 3. below in which case his/her appointment will be terminated. It is also agreed that these appointments will be renewed or terminated in accordance with schedules and rules which apply to University faculty, generally.

The residents in integrated residency programs will be appointed by the director of the parent department of the College who also will determine all residency rotations and assignments.

4. Program directors and others with college faculty appointments may be requested to serve on college and departmental faculty committees such as those dealing with medical school policy, admissions, curriculum, tenure and promotion.

5. Continuation of faculty appointment will be dependent upon the discharge of teaching and other responsibilities in the College as mutually determined by the departments of the College and the Affiliated Hospitals. Upon termination of these responsibilities or a demonstrated failure to carry them out, the faculty appointment will be terminated.

C. Faculty and House Staff Appointments.

1. In accordance with current University of Cincinnati policies and University Hospital bylaws, appropriate faculty and University Hospital medical staff appointments will be conferred on medical staff members of the Affiliated Hospitals who are qualified; who wish to participate on a voluntary or full-time basis in the undergraduate and graduate programs of the College and the University Hospital; who are recommended for College appointments by the respective program directors of the Affiliated Hospital and the College department; and who are recommended for University medical staff appointment (as appropriate) by the Medical Executive Committee of the University Hospital. Continuation of such appointments will be dependent upon the discharge of teaching and/or other College responsibilities. Upon termination of teaching responsibilities such appointments shall also be terminated. Each Affiliated Hospital will continue to make its own appointments to its medical staff and to formulate its own policy with regard to medical staff appointments. In all residency programs affiliated

with the College, the department director of the College will select and appoint all members of the teaching staff in that residency program.

2. The respective directors of the parent departments of the College will be responsible for the selection, appointment and assignment of all residents in integrated programs. In affiliated residencies qualifications and backgrounds of all residents involved in teaching medical students in core clerkships or junior internships shall be provided to the Director of the College Department responsible for that core clerkship.

3. In the development of any new residency program in the Affiliated Hospitals, there will be joint planning among the appropriate departmental director, the Dean of the College and the representative(s) of the Affiliated Hospital before the program is initiated.

4. The full-time faculty based at the College may participate in the teaching programs at the Affiliated Hospitals, at the discretion of the College department director(s), the Dean and the program director(s) at the Affiliated Hospital(s). If a faculty member in the execution of teaching functions has patient contact, he/she must first obtain appropriate clinical privileges on the medical staff of the Affiliated Hospital(s), in accordance with the bylaws or code of regulations of the Affiliated Hospital(s) in question.

5. Any health service fees charged by the full-time faculty members of the College for services performed in an Affiliated Hospital will be billed through the appropriate practice plan of the College.

D. Affirmative Action.

Any faculty appointment made by the College pursuant to this agreement shall attempt to address affirmative action goals and will follow required pre-employment procedures toward that end.

VI. General Provisions.

A. Terms of the Agreement.

The term of this Agreement will be for three (3) years beginning on _____ 1989 and ending on _____ 1992 unless terminated earlier under the terms hereof. At the end of that time, the Agreement will be automatically renewed for one (1) year unless any party notifies all other parties that a review of the Agreement is needed within ninety (90) days of the end of an original or renewal term hereof.

B. Modification of the Agreement.

Modification or additions to this Agreement may only be made in writing and must be referred to the Interinstitutional Steering Committee for review and recommendation. In order to become effective, the modification and/or addition must be ratified and executed by the College and each Affiliated Hospital in order to become a part of this Agreement.

C. Termination of Agreement.

This Agreement may be terminated with or without cause by any of the parties with one (1) year's advanced written notice to all of the parties to the Agreement.

D. Notice.

The following addresses of the parties to this Agreement shall be used: Any notice required by the terms of this Agreement will be effective when made to each of the parties as follows:

E. Governing Law.

This Agreement shall be governed and construed under the laws of Ohio. IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates indicated.

University of Cincinnati

By:

Date:

Bethesda

By:

Date:

The Christ Hospital

By:

Date:

Children's Hospital

By:

Date:

Good Samaritan

By:

Date:

Jewish

By:

Date:

Note: Each of the signing institutions should be designated by its legal name.

CGG/dm/2350o

"ISSUES IN GRADUATE MEDICAL EDUCATION"

Discussion Questions

1. In consideration of the issues arising from the changes in GME funding, regulations and requirements, who should lead the necessary coordination - medical school, hospital, consortia, other? What role should the RRC's and ACGME have in this determination?

2. How can medical schools increase the output of primary care physicians? Restricting access to other specialty residencies has been suggested. Are there other alternatives?

3. If forced by funding to reduce the total number of residency positions, how would the reduction be accomplished? Who will made the decision(s)?

4. With the increasing number of restricting requirements by the RRC and subspecialty certification groups, how can medical schools assure the required balance between service and education?

5. Concerning participation in the training programs, how can medical schools increase minority representation, especially in the specialties where the numbers have been traditionally less? What should be the controls on U.S. and alien FMG's in graduate medical education? What constraints should be placed on individuals changing specialty after partially completing another?

6. What is the role of the dean in determining program participation in the various GME matches by programs sponsored by schools?

The following Anesthesiology Programs did not offer positions through the 1989\90 Match:

Howard University	Washington, DC
University of South Florida	Tampa, FL
University of Chicago	Chicago, IL
University of Illinois	Chicago, IL
Cook County Hospital	Chicago, IL
Charity Hospital	New Orleans, LA
Johns Hopkins University	Baltimore, MD
Beth Israel Hospital	Boston, MA
Brigham & Woman's Hospital	Boston, MA
Children's Hospital	Boston, MA
Children's Hospital	Detroit, MI
Sinai Hospital	Detroit, MI
St. Luke's Hospital	Kansas City, MO
Creighton University	Omaha, NB
St. Joseph Hospital & Medical Center	Paterson, NJ
Brookdale Hospital Medical Center	Brooklyn, NY
Methodist Hospital	Brooklyn, NY
Beth Israel Medical Center	New York, NY
St. Luke's-Roosevelt Hospital Center	New York, NY
Children's Hospital Medical Center	Akron, OH
Aultman Hospital	Canton, OH
Wright State University	Kettering, OH
University of Puerto Rico	San Juan, PR
Texas Heart Institute	Houston, TX

The following Orthopaedic Surgery Programs did not offer positions through the 1989\90 Match:

University of Alabama Medical Center	Birmingham, AL
Martin Luther King, Jr.-Drew Med Ctr	Los Angeles, CA
St. Mary's Hospital and Medical Center	San Francisco, CA
Howard University	Washington, DC
Cook County Hospital	Chicago, IL
Fort Wayne Medical Education Program	Fort Wayne, IN
Alton Oschner Medical Foundation	New Orleans, LA
University of Massachusetts Coordinated Programs	Worchester, MA
Southwestern Michigan Area Health Education Center	Kalamazoo, MI
Truman Medical Center	Kansas City, MO
University of Nebraska	Omaha, NB
Creighton University	Omaha, NB
Dartmouth-Hitchcock Medical Center	Hanover, NH
St. Luke's-Roosevelt Hospital Center	New York, NY
Albert Einstein Medical Center	Philadelphia, PA
University of Puerto Rico	San Juan, PR
University of Tennessee	Chattanooga, TN
Campbell Foundation (U of TN)	Memphis, TN
Texas Tech University	El Paso, TX
Baylor College of Medicine	Houston, TX
Eastern Virginia Graduate Sch of Med	Norfolk, VA

The following Diagnostic Radiology Programs did not offer positions through the 1989\90 Match:

University of South Alabama	Mobile, AL
UCSF-Fresno	Fresno, CA
West Los Angeles VAMC Wadsworth	Los Angeles, CA
White Memorial Medical Center	Los Angeles, CA
Mt. Zion Hospital and Medical Center	San Francisco, CA
Santa Clara Valley Medical Center	San Jose, CA
AMI Presbyterian-St. Luke's Med Ctr	Denver, CO
Howard University	Washington, DC
Memorial Medical Center	Savannah, GA
Illinois Masonic Medical Center	Chicago, IL
The Chicago Medical School (Mt. Sinai Hospital Medical Center)	Chicago, IL
Mercy Hospital and Medical Center	Chicago, IL
LSU (Shreveport)	Shreveport, LA
Mt. Carmel Mercy Hospital	Detroit, MI
Dartmouth-Hitchcock Medical Center	Hanover, NH
Winthrop-University Hospital	Mineola, NY
Harlem Hospital Center	New York, NY
Oral Roberts University	Tulsa, OK
Hahnemann University	Philadelphia, PA
University of Puerto Rico	San Juan, PR
University of Tennessee-Knoxville	Knoxville, TN
Baptist Memorial Hospital	Memphis, TN
Methodist Hospital	Memphis, TN
Baylor College of Medicine	Houston, TX

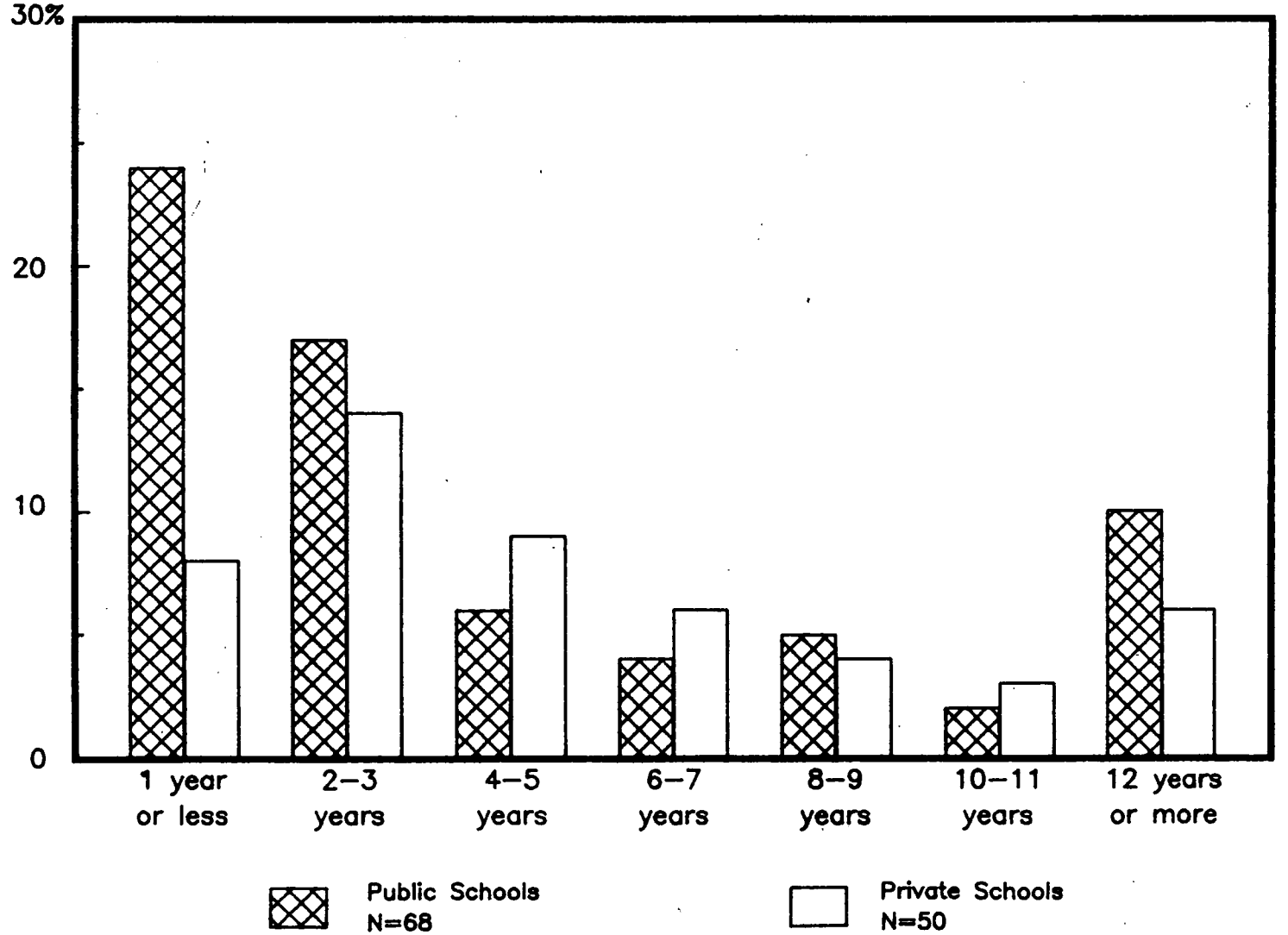
MEDIAN YEARS OF SERVICE

YEAR	PUBLIC	PRIVATE	ALL SCHOOLS
1980-81	4.00 (61)	5.00 (39)	5.00 (100)
1981-82	5.00 (65)	5.00 (44)	5.00 (109)
1982-83	5.00 (65)	3.00 (43)	4.00 (108)
1983-84	5.00 (64)	2.50 (44)	3.50 (108)
1984-85	5.00 (67)	2.50 (42)	4.00 (109)
1985-86	5.00 (69)	3.00 (43)	4.00 (112)
1986-87	5.00 (66)	4.00 (46)	4.00 (112)
1987-88	4.00 (68)	5.00 (43)	4.00 (111)

Source: Deans Compensation Survey.

Figure I

Distribution of Deans by Number of Years at Current Institution 1988–89



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

12:30 pm - 1:45 pm
Santa Rosa East
Fess Parker's Red Lion Resort
Santa Barbara, California

Friday, April 14, 1989

AGENDA

I.	Call to Order 12:45	
II.	Report of the Chairman	
III.	Preparation of Discussion Groups' Reports and Strategies	
IV.	VA/COD Annual Meeting Planning Committee	
V.	Annual Meeting Sunday Afternoon Session	
VI.	Deans' Dinner, Annual Meeting	
VII.	Meeting Site for Spring 1991	TAB F
VIII.	Conflict Dates for Spring 1990 Meeting	TAB G
IX.	Other Business	
X.	Adjournment	

January 11, 1989
Today's Temperature 67'

Ms. Gladys Peters
Program Director
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
One Dupont Circle
Washington, DC 20036

Dear Ms. Peters

It was a pleasure to learn from Ford Thompson of Capitol Representation, that your interested in Phoenix, Arizona as a possible destination for your 1991 "The Council of Deans" program.

As for AAMC coming to The Pointe on South Mountain, we would welcome the opportunity to host this event and show you why The Pointe Resorts are Four Star and Five Diamond Award Winners.

Our resort is specially designed to accommodate meetings your size. With all suites and 85,000 square feet of meeting space, we could facilitate all your meeting and food and beverage requirements in our Convention Complex. Would like to high-light some nice features of these items.

ACCOMMODATIONS: All Two-Room Suites featuring:
Living room with separate bedroom and bath
Private balcony
Two color televisions
Refrigerator/Wet-bar

CONVENTION COMPLEX: The Most Complete in Arizona, Offering:
20,000 square foot Grande Ballroom
20,000 square foot Symposium Pavilion
8,000 square foot South Mountain Ballroom
Three, 2,000 square foot Courtrooms
Twenty-six Executive Boardroom Suites
Ten Presidential Suites

Feel as though your (13) break-outs on Sunday could be accommodated in our Executive Boardroom Suites. All General Sessions and remaining break-outs on Monday and Tuesday will fit nicely in our Grande Ballroom.

The following dates are available for your consideration:

MONTH:	APRIL 1991			
DAYS:	SUN	MON	TUE	WED
DATES:	07	08	09	10
SUITES:	165	165	165	52

The Pointe
on South Mountain

Mountainside Golf, Riding and Racquet Resorts
7777 S. Pointe Parkway, Phoenix, AZ 85044 • (602) 438-9000

Preferred Hotels Worldwide

The Pointe on South Mountain is offering the following guaranteed special group rates for AAMC.

$180.00 per day, Single Occupancy
$180.00 per day, Double Occupancy
$250.00 per day, Executive Board Room Suite
$300.00 per day, Presidential Suite
$800.00 per day, Super Suite

One of the advantages our resort has over the competition, is that we are located only ten minutes from Sky Harbor International Airport; this will save you and your attendees both money and time. All your transportation needs can be arranged through our in-house ground operator, Pointe to Pointe Transportation.

The Pointe on South Mountain offers additional amenities, which work in nicely with the remainder of your program.

RECREATION:
18-hole championship golf
Six heated swimming pools
Ten lighted tennis courts
Racquetball
Horseback riding
35,000 square foot Executive Fitness Centre & Spa
(Ideal for Monday Afternoons Golf & Tennis Play)

DINING PLEASURES:
We offer a taste of the Old West at Rustler's Rooste
Have a Mexican Fiesta at Aunt Chilada's
Gourmet delights at Another Pointe In Tyme
Dancing or casual dining at The Sport Club
*All four restaurants are located on property

HOSTED COCKTAILS:
To make all of our guest's feel welcome, each evening from 4:30-6:00 PM, poolside, we offer a Complimentary Management Hosted Cocktail Reception

Ms. Peters, I sincerely hope the enclosed information will assist you in coordinating your 1991 program. We would welcome the opportunity to submit our formal Letter of Agreement outlining your specific dates and accommodations, as well as our procedures for confirming your group at The Pointe on South Mountain.

Will be calling you within the next few weeks to answer any question you may have. In the interim, should you need any additional information, please feel free to give me a call.

Warmest regards,

Kevin P. O'Brien

Kevin P. O'Brien
Sales Manager

cc: Ford Thompson, Capitol Representation

KPO/klw
enclosures

FACT SHEET

A total destination luxury golf resort, The Pointe at South Mountain features Spanish Mediterranean architecture situated adjacent to the largest municipal mountain park in the world. More than 85,000 square feet of function space is available, including a beautifully designed, multilevel Convention Complex with a 20,000-square-foot Grande Ballroom, 8,000-square-foot South Mountain Ballroom and 20,000-square-foot Exhibit Pavilion.

ACCOMMODATIONS

- 640 spacious two-room suites featuring:
  - Living room/den with separate bedroom and bath
  - Two color televisions
  - Refrigerator and wet bar
  - A desk with a telephone (two phones per suite, with two lines)
  - Private balcony
- Deluxe accommodations including 10 Presidential suites and 26 Executive Boardroom suites are also available

CONVENTION COMPLEX

- 20,000-square-foot Grande Ballroom
- 8,000-square-foot South Mountain Ballroom
  - 110- and 220-volt electrical outlets; 30-, 60- and 100-amp capabilities; dedicated phone lines in each section
  - Recessed fluorescent or incandescent lighting available
  - Shipping and receiving loading docks for incoming and outgoing package and exhibit needs
  - Storage space available for meeting equipment
- 20,000-square-foot Exhibit Pavilion
- Three 2,000-square-foot break-out rooms (divisible by two)
- Two 10,000-square-foot Patio Gardens
- Banquet Kitchen located within the Convention Complex complete with an award-winning catering staff
- Nationwide teleconferencing facilities and equipment
- Convention Planner office facilities

RECREATION

- Seven heated pools
- 10 lighted tennis courts
- 18-hole championship golf course
- Horseback riding into adjacent 30,000-acre Phoenix mountain park
- 35,000-square-foot Executive Fitness Centre including:
  - Seven indoor racquetball, squash and handball courts
  - 25-yard Olympic lap pool
  - Medical and fitness diagnostic testing
  - Weight training
  - Aerobics room
  - Complete spa amenities
  - Masseuse/Masseur

DINING PLEASURES

- **Pointe In Tyme**® – highlighting "signature menu items" from the nation's finest restaurants, in turn-of-the-century atmosphere.
- **Beside The Pointe**® – a casual garden eatery with more than 150 different menu items to choose from.
- **Aunt Chilada's**™ – spicy and authentic Mexican entrées served in the midst of a lush orange grove.
- **Rustler's Rooste**™ – Western-style mountaintop dining with mesquite-grilled fixin's and a panoramic view of the city lights. Outdoor seating available for 1,200.

The Pointe®
at South Mountain

Mountainside Resorts, Riding, Health and Country Clubs

7777 South Pointe Parkway • Phoenix, Arizona 85044 • (602) 438-9000

November 7, 1988

Gladys Peters
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
One Dupont Circle
Washington, D.C. 20036

Dear Gladys:

I was happy to learn from Dave Bambrick of Hyland & Bambrick about the Deans Conference you are planning to be held in the West in April of 1991. I currently have several dates available during that time frame and have outlined my understanding of your program requirements below.

FUNCTION: Deans Conference

DATES: April, 1989

ATTENDANCE: 300 people

ROOM BLOCK

MONTH: April, 1991

DAYS:	FRI	SAT	SUN	MON	TUE	WED
DATES:	To be determined					
ROOMS:	50	150	150	100	100	0

ROOM RATES: $145.00 for April of 1989

We do not anticipate more than a ten percent increase per year. Towards the end of April, rates become a little more negotiable.

Sales tax on sleeping rooms is currently 8.9 percent and Westcourt In The Buttes does provide complimentary transportation to and from Phoenix Sky Harbor Airport.

RECREATIONAL FACILITIES

Westcourt In The Buttes does have a number of recreational facilities on property and nearby to accommodate your attendees unstructured free time. Those activities include:

Five outdoor lighted tennis courts.

An executive fitness center featuring universal weight equipment, aerobicycles, massage room, sauna and aerobic classes.

Free form pool with cascading waterfall.

Jogging trails throughout the property ranging in distance from one to six miles.

Two mountainside spas.

Access to a number of championship golf courses.

RESTAURANTS & ENTERTAINMENT

On property Westcourt In The Buttes offers the Market Cafe for breakfast, lunch and dinner and Top Of The Rock Restaurant featuring fine dining for lunch and dinner. In addition to this we have a pool bar available from 11:00 a.m. to 6:00 p.m. and 24-hour room service daily. For nightly entertainment our Top Of The Rock Bar features entertainment and drink specials each evening with live bands Wednesday through Sunday.

CONCLUSION

Gladys, thank you in advance for you consideration. Needless to say, we would love the opportunity to work with you on this program. I had the opportunity to meet with Marcie Foster here at Westcourt In The Buttes a couple of months ago and I am sure she would be more than happy to tell you about the property first hand. Please feel free to contact me with any questions you may have.

Sincerely,

M. Hahn

Miriam Hahn
Sales Manager

cc: Dave Bambrick - Hyland & Bambrick

FACT SHEET

Location: Less than ten minutes from Phoenix Sky Harbor International Airport; nestled in the saddle of twin volcanic buttes, overlooking the Valley of the Sun.

Accommodations: 300 Luxury-style guest rooms located on 4 floors and including a 70-room Concierge Club Level. All guest rooms come equipped with stocked mini bars, remote control TV, hairdryers, Spectravision Movies and amenities.

Conference Facilities: Over 25,000 square feet of usable convention space. Featured is a 140 seat Amphitheatre, 9000 square foot Ballroom with 4000 square feet of prefunction space, and a 10,000 square foot Exhibition Hall. An Audio Visual Center is located right on property fully equipped and staffed.

Dining and Entertainment

Top Of The Rock Restaurant - Casual elegance, breathtaking views of the valley below
Market Cafe - Dine amidst natural rock formations and cascading waterfalls
Top Of The Rock Lounge - Live entertainment and dancing nightly
Lobby Bar
Pool Bar and Grill

Executive Business Center: Located in the main lobby, providing total secretarial services for guests use, equipped with work processing, personal computer, telex machine, copy service and facsimile.

Recreational Amenities:

Free-form heated swimming pool with waterfall
Two remote mountainside spas
Five outdoor lighted tennis courts
Executive Fitness Center with universal weight equipment, sauna, masseur, aerobics classes and aerobicycles
Jogging and hiking trails
Championship golf nearby.

Guest Services & Shops

Gift Shop
Rental Car Desk
Tour Desk
Concierge
In-House Audio/Visual Capabilities
Laundry/Valet Service
Complimentary shuttle service to and from Phoenix Sky Harbor International Airport

1990 COD SPRING MEETING

Request to Change Dates

The dates of the 1990 COD Spring Meeting (April 7-11) conflict with Passover (April 10-17), a traditionally celebrated Jewish holiday. Observance will begin sunset, April 9, 1990. Therefore, it is proposed that the 1990 Spring Meeting dates be changed.

Suggestions: March 31 - April 4, 1990 1st
(In: Saturday - Out: Wednesday)

April 3 - 7, 1990
(In: Tuesday - Out: Saturday)

Future Passover dates: March 30 - April 6, 1991
April 18 - 25, 1992

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • Fax (312) 645-4184 • Telex 28-0248

DIVISION OF UNDERGRADUATE MEDICAL EDUCATION

HARRY S. JONAS, M.D.
Director
(312) 645-4657

BARBARA BARZANSKY, Ph.D.
Assistant Director
(312) 645-4690

CRISTYN A. CARLSON
Administrative Assistant
(312) 645-4662

March 27, 1989

TO : Presidents or Chancellors of Universities with Liaison Committee on Medical Education (L.C.M.E.) Approved Medical Schools

FROM : Harry S. Jonas, M.D., Director
Division of Undergraduate Medical Education

SUBJECT : The Search Process for Medical School Deans

Concern has been expressed in the medical education community about the turnover of medical school deans. There has not been much systematic study of the process by which new deans are selected and the problems that commonly are encountered during the search. More specifically, we only have anecdotal data about the structure, length and cost of the search process. The purpose of this survey is to collect data from all institutions with L.C.M.E. accredited medical schools to remedy this deficiency. The data should be helpful to us and to you as a means to describe and evaluate the academic search process.

I would appreciate your completing the enclosed questionnaire and returning it to me by May 1, 1989. All responses will be kept confidential, and only aggregate data will be reported. After the data have been analyzed, I will share the results with you. Thank you for your cooperation.

enclosure

MEDICAL SCHOOL — Baylor College of Medicine —

SEARCH PROCESS FOR
MEDICAL SCHOOL DEAN

1. Was the position of dean of the medical school at your institution vacant at any time between JANUARY 1, 1986 and DECEMBER 31, 1988? (include vacancies that occurred before January 1, 1986 and continued after that date)

YES NO

IF YES, PLEASE COMPLETE QUESTIONS 2 TO 18. IF NO, GO TO QUESTION 19.

2. What was the date when the resignation of the dean was announced?

_____

3. What was the date when the dean left office?

_____

4. Which of the following best matches your current situation with regard to the position of dean of the medical school? (check one)

a. A new dean has taken office _____

b. An offer has been made and accepted but the new dean has not yet taken office _____

c. A search is still underway _____

d. No search has yet been organized _____

IF THE SEARCH PROCESS HAS BEEN COMPLETED (a or b above), PLEASE ANSWER QUESTIONS 5 - 7. IF THE SEARCH IS STILL UNDERWAY, GO TO QUESTION 8.

5. How long was the time between the dean's announced resignation and the offer to the permanent replacement (new dean)?

_____

6. What was (will be) the date when the new dean assumed (assumes) office?

_____

7. Was there an acting/interim dean?

YES NO

If YES, how long did this individual serve?

_____

8. Did you use/are you using an executive search service or consultant in the recruitment process for the new dean?

YES NO

If YES, how satisfied were/are you with the service?

Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied

IF A SEARCH COMMITTEE WAS APPOINTED TO FILL THE DEAN POSITION, PLEASE ANSWER QUESTIONS 9 - 11. IF THERE WAS NO SEARCH COMMITTEE, PLEASE GO TO QUESTION 12.

9. How many members did the search committee have?

_____

Please supply the rank/position and department of the search committee chair.

_____

10. Were there members of the search committee who were not faculty/administrators of the medical school? (for example, faculty/administrators from other campus units, community physicians)

YES NO

If YES, how many committee members were from outside the medical school?

_____

11. Did the search committee have staff support?

YES NO

If YES, from what unit? (for example, dean's office)

_____

12. Which of the following means were/are being used to recruit candidates for the dean position? (check all that apply)

advertisements in journals or other publications _____

letters to potential candidates _____

letters to potential nominators _____

placement services of professional associations (please list): _____

other (please list): _____

IF THE SEARCH PROCESS HAS BEEN COMPLETED, PLEASE ANSWER QUESTIONS 13 TO 18. IF THE PROCESS IS STILL UNDERWAY, GO TO ITEM 19.

13. How many applicants were interviewed for the position?

_____

14. What was the previous position of the successful candidate? (for example, dean, department head)?

_____

15. Was the successful candidate previously employed at your medical school (that is, before selection as dean)?

YES NO

16. What was the approximate total cost of the search process (excluding the time of search committee members)?

_____

17. The budget for the search came from which unit(s)?

_____

USE THIS SCALE WHEN ANSWERING QUESTION 18:
5 = VERY SATISFIED: 3 = SOMEWHAT SATISFIED; 1 = NOT AT ALL SATISFIED

18. How satisfied were you with the following aspects of the search process? (circle your answer)

length of search process	5	4	3	2	1
cost of the search	5	4	3	2	1
efficiency of the search	5	4	3	2	1
number of suitable candidates	5	4	3	2	1

19. Would you be interested in a professional search service to assist in the recruitment of medical school deans and department heads if that service possessed the requisite expertise and experience? (circle your answer)

YES NO UNSURE

20. For which aspects of the recruitment process might you use a search service either alone or in conjunction with an institutional search committee (check all that apply)

for identifying a pool of candidates _____

for initial screening of candidates _____

for interviewing candidates _____

other (please list): _____

21. Which of the following would be IMPORTANT in your decision to use a search service? (check all that apply)

a service that lowers the costs of a search _____

a service that shortens the search process _____

a service that helps you identify a better pool of candidates _____

a service that reduces the work load of faculty/staff _____

Name and Title of Individual Completing Questionnaire:

William D Butler
President

Telephone Number:

Baylor Coll of Med
713 798 4846

PLEASE RETURN THE COMPLETED QUESTIONNAIRE BY MAY 1, 1989 TO:

Harry S. Jonas, M.D.
Director
Division of Undergraduate Medical Education
American Medical Association
535 North Dearborn
Chicago, Illinois 60610

→ Lou

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • Fax (312) 645-4184 • Telex 28-0248

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March 27, 1989

TO : Deans of Liaison Committee on Medical Education (L.C.M.E.) Accredited Medical Schools

FROM : Harry S. Jonas, M.D., Director
Division of Undergraduate Medical Education

SUBJECT : The Search Process for Medical School Department Heads

Concern has been expressed in the medical school community about the turnover of department heads in the basic and clinical sciences. There has not been much systematic study of the means by which new department heads are selected and the problems that commonly are encountered during the search. More specifically, we only have anecdotal data about the stucture, length, and cost of the search process. The purpose of this survey is to collect data from all L.C.M.E. accredited medical schools to remedy this deficiency. The data should be helpful to us and to you as a means to describe and evaluate the academic search process.

I would appreciate your completing the enclosed questionnaire and returning it to me by May 1, 1989. All responses will be kept confidential, and only aggregate data will be reported. After the data have been analyzed, I will share the results with you. Thank you for your cooperation.

enclosure

MEDICAL SCHOOL — Baylor College of Medicine

SEARCH PROCESS FOR DEPARTMENT HEADS

1. Was the headship/chairmanship of one or more medical school departments vacant between JANUARY 1, 1986 and DECEMBER 31, 1988?

YES NO

. If YES, for each department where the headship/chairmanship was vacant at some time between JANUARY 1, 1986 and DECEMBER 31, 1988, please supply the information requested below. (include vacancies that occurred before January 1, 1986 and continued after that date)

Name of Department	Date Previous Head Announced Resignation	Date Previous Head Left Office*	Date Offer Made to Permanent Replacement*	Date Permanent Replacement Took Office*

* if these events have not yet occurred, use N/A in space

2. Were any research grants lost to the medical school in conjunction with the departure of one or more department heads?

YES NO

If YES, what was the total amount of the funding loss (including all departments where relevant)?

_____

3. Could the departure of any faculty members be directly linked to the departure of one or more department heads?

YES NO

SEARCH PROCESS

4. Of the completed searches (offer made and accepted or new head in office), how many of the new heads came from within your medical school?

_____

5. Did you use/are you using an executive search service or consultant in the recruitment of department heads?

YES NO

If YES, how satisfied were/are you with the service?

Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied

IF SEARCH COMMITTEES WERE APPOINTED TO FILL THE DEPARTMENT HEAD POSITIONS, PLEASE ANSWER QUESTIONS 6 - 9. IF NO SEARCH COMMITTEES ARE USED IN THE RECRUITMENT PROCESS, GO TO QUESTION 10.

6. About how many members does the average search committee have?

_____

If there is significant variation in search committee size, please give range.

_____

7. In the search for the head of a BASIC SCIENCE department, approximately what <u>percentage</u> of search committee members come from:

the department that is recruiting the head _____

other medical school basic science departments _____

medical school clinical departments _____

other health professions schools _____

other (please list): _____

TOTAL = 100%

8. In the search for the head of a CLINICAL department, approximately what percentage of search committee members come from:

the department that is recruiting the head _____

other medical school clinical departments _____

medical school basic science departments _____

other health professions schools _____

physicians who are not medical school faculty (for example, community physicians) _____

other (please list): _____

TOTAL = 100%

9. Do search committees for department heads typically have staff support?

YES NO

If YES, from what unit? (for example, the dean's office)

_____

10. Which of the following means are typically used to recruit candidates for the department head position? (check all that apply)

advertisements in journals or other publications _____

letters to potential candidates _____

letters to potential nominators _____

placement services of professional associations (please list): _____

other (please list): _____

11. How many candidates are typically interviewed for the department head position?

_____

12. Does a candidate for a department head position typically present a public seminar on his/her research?

YES NO

13. What is the approximate total cost of the search for a department head (excluding the time of search committee members)?

_____

14. The budget for a department head search typically comes from what unit(s)?

_____

USE THIS SCALE WHEN ANSWERING QUESTION 15:
5 = VERY SATISFIED; 3 = SOMEWHAT SATISFIED; 1 = NOT AT ALL SATISFIED

15. How satisfied are you with the following aspects of the search process for department heads at your institution?

length of the process	5	4	3	2	1
cost of the search process	5	4	3	2	1
efficiency of the search process	5	4	3	2	1
number of suitable candidates identified	5	4	3	2	1

16. Would you be interested in a professional search service to assist you in the recruitment of medical school department heads if that service possessed the requisite expertise and experience?

YES NO UNSURE

17. For which aspects of the recruitment process might you use a search service either alone or in conjunction with a search committee? (check all that apply)

for identifying a pool of candidates _____

for initial screening of candidates _____

for interviewing candidates _____

other (please list): _____

18. Which of the following would be IMPORTANT in your decision to use a search service? (check all that apply)

a service that lowers the costs of a search _____

a service that shortens the process _____

a service that helps you identify a better pool of candidates _____

a service that reduces the work load of faculty/staff _____

Name and Title of Individual
Completing Questionnaire: _____

_____

Telephone Number: _____

PLEASE RETURN THE COMPLETED QUESTIONNAIRE BY **MAY 1, 1989** TO:

Harry S. Jonas, M.D.
Director
Division of Undergraduate Medical Education
American Medical Association
535 North Dearborn
Chicago, Illinois 60610

ISSUES OF LOWER CLASS SIZE, THE IMPACT ON FUNDING, STUDENT RECRUITMENT, GRADUATE EDUCATION

Council of Deans
April 12-15, 1989

U.S. Medical schools endeavor to provide the U.S. public with quality physicians by participating in a rigorous accreditation process, by the careful admissions process which selects academically and personally qualified applicants, and by a stringent educational program with internal and external evaluations.

Various factors have led some schools to decrease the size of their entering class, including:

The continued decline in the quantity and academic quality of the applicant pool. (Figures I and II)

The response to the national and/or local concern of over-supply of physicians.

This decision to decrease class size directly impacts upon school finances, the recruitment of students, and may indirectly affect the quality of care to the U.S. public.

FINANCIAL IMPACT

The Amount of reduction in the number of enrolled students gives a proportional decrease in finances affecting the tuition income of the private schools and the per capita support of the public schools.

QUESTIONS FOR CONSIDERATION

(a) How will medical schools cope with the financial down turn without destabilizing their programs?

(b) In 1994, there will no longer be mandatory retirement for faculty in academic institutions. In what ways will schools facing a decrease in financial support be able to continue to be invigorated by the appointment of young faculty while at the same time, handle the expense of an aging faculty?

(c) What, if any, state or federal financial assistance could be provided?

RECRUITMENT OF STUDENTS

In the 70's, admissions committees faced the dilemma of selecting between very desirable candidates when there was a very large applicant pool. In the past 30 years, the number of U.S. medical schools has increased from 86 in 1959 to 127 in 1989. Now we are faced with a decline in interest in medicine, and various short and long range programs are being developed to encourage academically qualified students to pursue a career in medicine.

In addition, special emphasis is being placed upon the recruitment and retention of under-represented minorities (Figure III) and black applicants aiming to provide competent professionals for service to these ethnic groups.

QUESTIONS FOR CONSIDERATION

1. What, if anything, should be done to allow medical schools to more rapidly increase the size of the entering class (assuming they have appropriate institutional resources) when the pendulum swings towards a physician deficit and when the pool of qualified applicants rises in response to a successful recruitment program?

2. What considerations should be given to institutions actively recruiting and training ethnic minorities so that this special health care need can be met?

GRADUATE TRAINING PROGRAMS

U.S. medical schools are proactive in quality control of the educational process, responsive to the physician supply issue and committed to providing the U.S. public with excellent health care.

The number of graduates of U.S. schools has been decreasing for the past 4 years and will continue to decline as various institutions decrease their number of matriculation.

At the same time, there is a progressive increase in the number of PGY slots available for residency training. The national resident matching data (Table I) displays the increasing discrepancy between the number of U.S. seniors and the PGY$_1$positions available and the ever-increasing number of other trainees who are entering the Graduate Education process. Categories of applicants filling the 1989 PGY$_1$slots is displayed in Table II.

QUESTIONS FOR CONSIDERATION

1. How effective will U.S. medical school efforts be to address physician supply and quality of care issues while this discrepancy continues?

2. Recognizing the financial burden that graduate education places on the health care industry, do the U.S. medical schools have any responsibility for this growing discrepancy?

STATISTICS FROM THE NATIONAL RESIDENT MATCHING PROGRAMS

Table I

NUMBER OF PGY1 SLOTS AND ACTIVE APPLICANTS

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Total # of PGY1 Slots	18,055	18,331	18,300	17,952	18,457	18,535	18,770	19,047	19,513	19,955
ACTIVE APPLICANTS										
US Seniors	13,222	13,705	14,144	13,969	14,741	14,849	14,737	14,446	14,499	14,117
Canadian	50	53	47	54	91	56	62	85	66	70
US Physicians	176	181	322	597	768	833	951	907	958	1,010
Osteopaths	127	152	132	135	206	348	402	517	600	685
5th Pathway	411	350	430	366	339	352	240	170	128	131
US Foreign Grads	–	536	943	1,305	1,695	1,692	1,303	1,041	1,020	881
Alien Foreign Grads	1,143	1,127	2,392	3,618	4,212	4,256	3,662	2,868	2,537	2,313
Total	15,129	16,104	18,410	20,044	22,052	22,386	21,357	20,054	19,808	19,207

Source of Data:
National Resident Matching Program

TABLE II - DATAGRAM

POSITIONS OFFERED AND FILLED BY TYPES OF APPLICANTS IN 1989

	PGY1 POSITIONS OFFERED		APPLICANTS MATCHED											
			U.S.SENIOR STUDENTS			OTHER U.S. APPLICANTS+			FOREIGN-BORN FOREIGN GRADUATES			TOTAL APPLICANTS		
				PERCENT			PERCENT			PERCENT			PERCENT	
	NO.	PERCENT*	NO.	*	#	NO.	*	#	NO.	*	#	NO.	*	#
FAMILY PRACTICE	2456	12.3	1468	11.1	59.8	216	14.0	8.8	61	4.9	2.5	1745	10.9	71.1
INTERNAL MEDICINE	7467	37.4	4744	35.9	63.5	550	35.6	7.4	706	56.3	9.5	6000	37.5	80.4
PEDIATRICS	2068	10.4	1256	9.5	60.7	156	10.1	7.5	242	19.3	11.7	1654	10.3	80.0
OBSTETRICS/GYNECOLOGY	1061	5.3	883	6.7	83.2	100	6.5	9.4	24	1.9	2.3	1007	6.3	94.9
PSYCHIATRY	1095	5.5	722	5.5	65.9	98	6.3	8.9	77	6.1	7.0	897	5.6	81.9
MEDICAL SPECIALTIES	72	0.4	45	0.3	62.5	4	0.3	5.6	4	0.3	5.6	53	0.3	73.6
DERMATOLOGY	9	0.0	9	0.0	100.0	0	0.0	---	0	0.0	---	9	0.0	100.0
NEUROLOGY	44	0.2	22	0.2	50.0	4	0.3	9.1	3	0.2	6.8	29	0.2	65.9
OPHTHALMOLOGY	19	0.1	14	0.1	73.7	0	0.0	---	1	0.1	---	15	0.1	78.9
GENERAL SURGERY	2218	11.1	1532	11.6	69.1	141	9.1	6.4	51	4.1	2.3	1724	10.8	77.7
SURGICAL SPECIALTIES	632	3.2	547	4.1	86.6	50	3.2	7.9	2	0.2	0.3	599	3.7	94.8
NEUROSURGERY	33	0.2	23	0.2	69.7	3	0.2	9.1	1	0.1	---	27	0.2	81.8
ORTHOPEDIC SURG	462	2.3	415	3.1	89.8	41	2.7	8.9	1	0.1	---	457	2.9	98.9
OTOLARYNGOLOGY	50	0.3	40	0.3	80.0	2	0.1	4.0	0	0.0	---	42	0.3	84.0
UROLOGY	79	0.4	63	0.5	79.7	2	0.1	2.5	0	0.0	---	65	0.4	82.3
PLASTIC SURGERY	8	0.0	6	0.0	75.0	2	0.1	---	0	0.0	---	8	0.0	100.0
SUPPORT SPECIALTIES	1598	8.0	1108	8.4	69.3	171	11.1	10.7	34	2.7	2.1	1313	8.2	82.2
ANESTHESIOLOGY	293	1.5	200	1.5	68.3	9	0.6	3.1	5	0.4	1.7	214	1.3	73.0
EMERGENCY MEDICINE	376	1.9	297	2.2	79.0	56	3.6	14.9	2	0.2	0.5	355	2.2	94.4
PATHOLOGY	475	2.4	253	1.9	53.3	30	1.9	6.3	22	1.8	4.6	305	1.9	64.2
PHYSICAL MEDICINE	89	0.4	84	0.6	94.4	2	0.1	2.2	0	0.0	0.0	86	0.5	96.6
PREVENTIVE MEDICINE	10	0.1	2	0.0	20.0	0	0.0	---	0	0.0	0.0	2	0.0	20.0
DIAGNOSTIC RADIOLOGY	344	1.7	262	2.0	76.2	74	4.8	21.5	5	0.4	1.5	341	2.1	99.1
THERAPEUTIC RADIOLOGY	10	0.1	9	0.1	90.0	0	0.0	---	0	0.0	0.0	9	0.1	90.0
NUCLEAR MEDICINE	1	0.0	1	0.0	100.0	0	0.0	0.0	0	0.0	0.0	1	0.0	100.0
TRANSITIONAL	1288	6.5	910	6.9	70.7	59	3.8	4.6	52	4.2	4.0	1021	6.4	79.3
TOTAL	19955	100.0	13215	100.0	66.2	1545	100.0	7.7	1253	100.0	6.3	16013	100.0	80.2

* PERCENT DISTRIBUTIONS POSITIONS OFFERED AND FILLED AMONG SPECIALTIES (PERCENTAGES MAY NOT ADD TO 100 DUE TO ROUNDING)
# PERCENT OF POSITIONS OFFERED IN SPECIALTY THAT WERE FILLED BY APPLICANTS.

+ This category consists of those students listed in the footnote to Table I plus U.S. foreign medical graduates.

FIGURE I

Number of Medical School Applicants and Matriculants 1960 to 1988

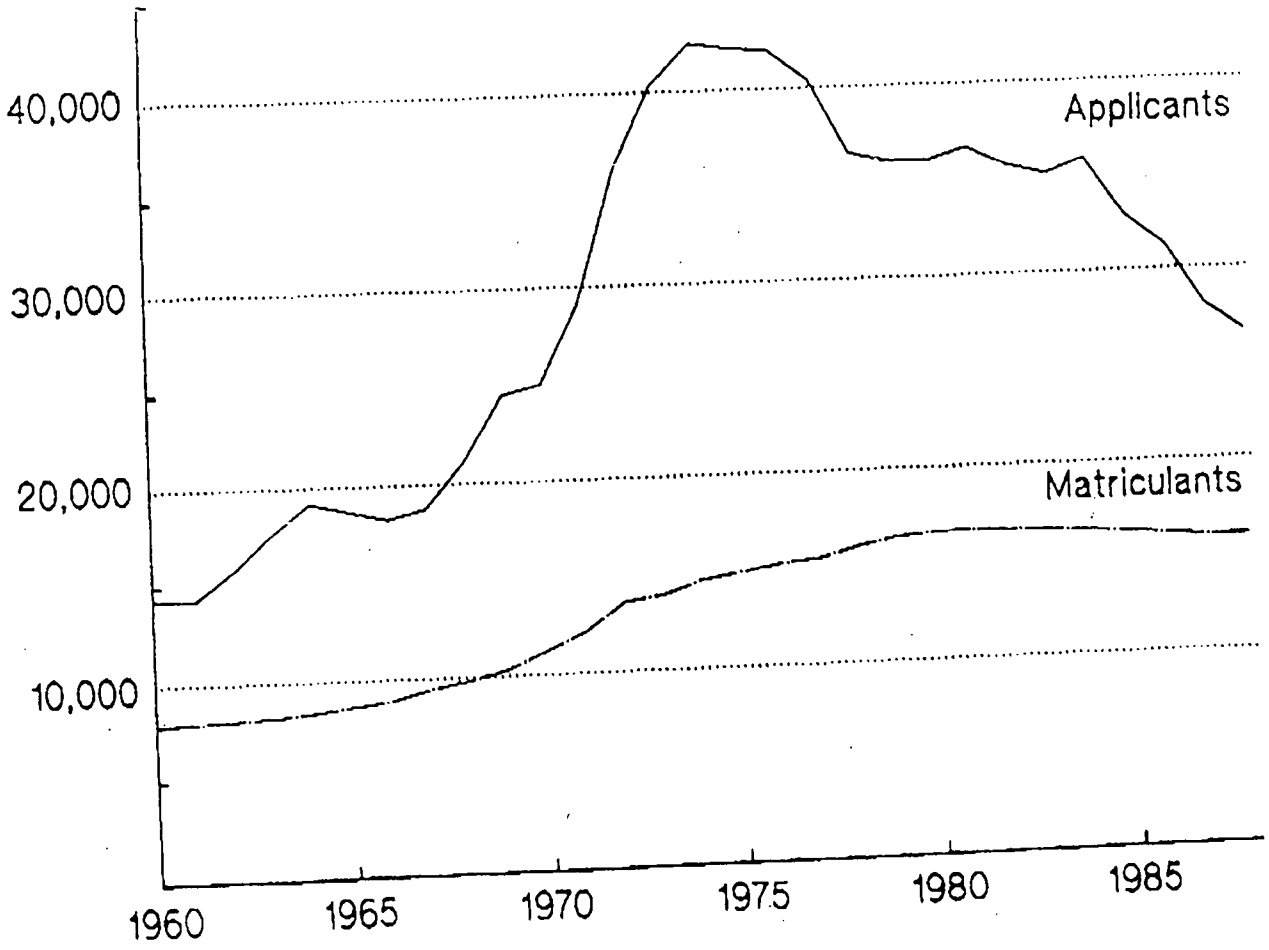


FIGURE II A

Overall Grade Point Average of Applicants and Matriculants 1981 and 1988

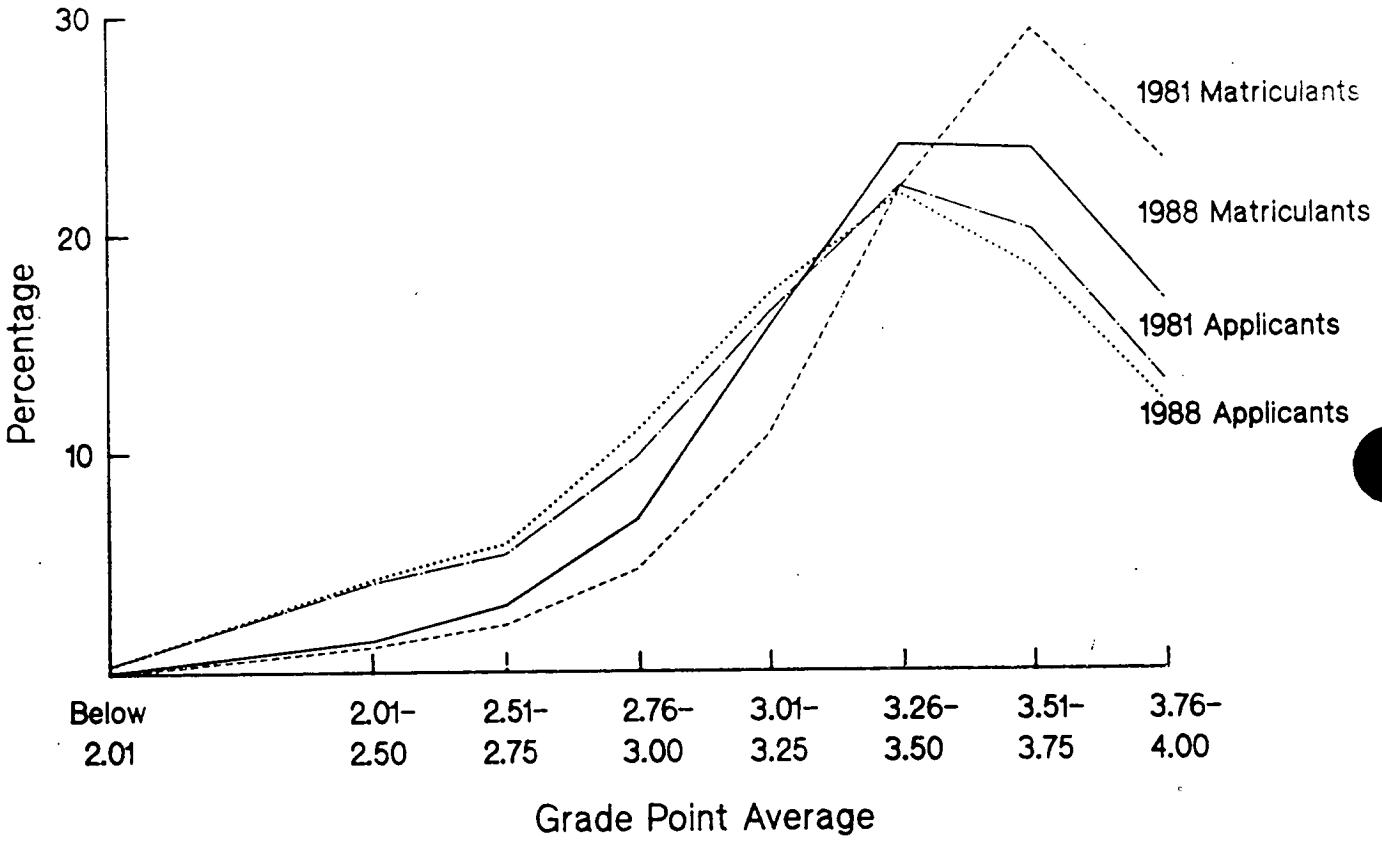


FIGURE II B

Science Grade Point Average of Applicants and Matriculants 1981 and 1988

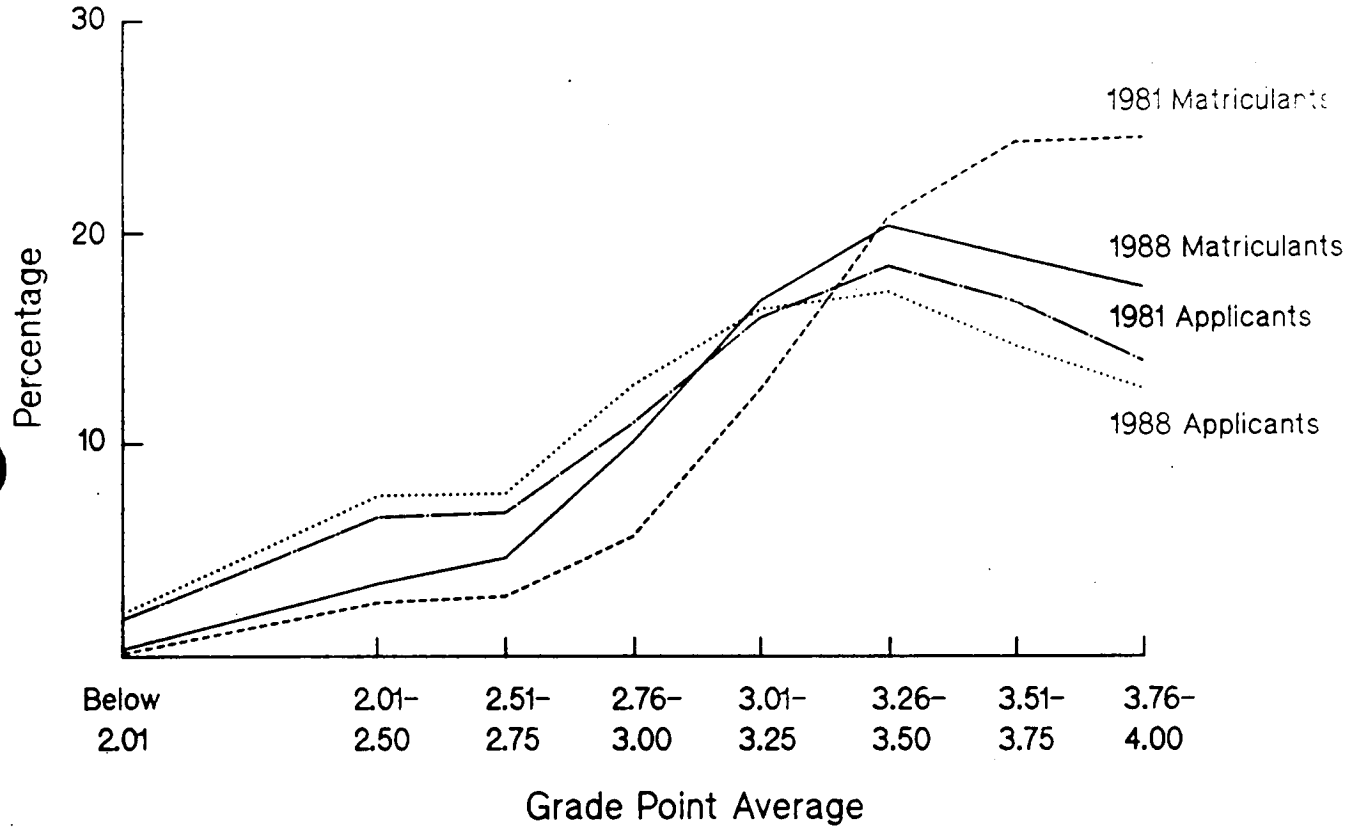
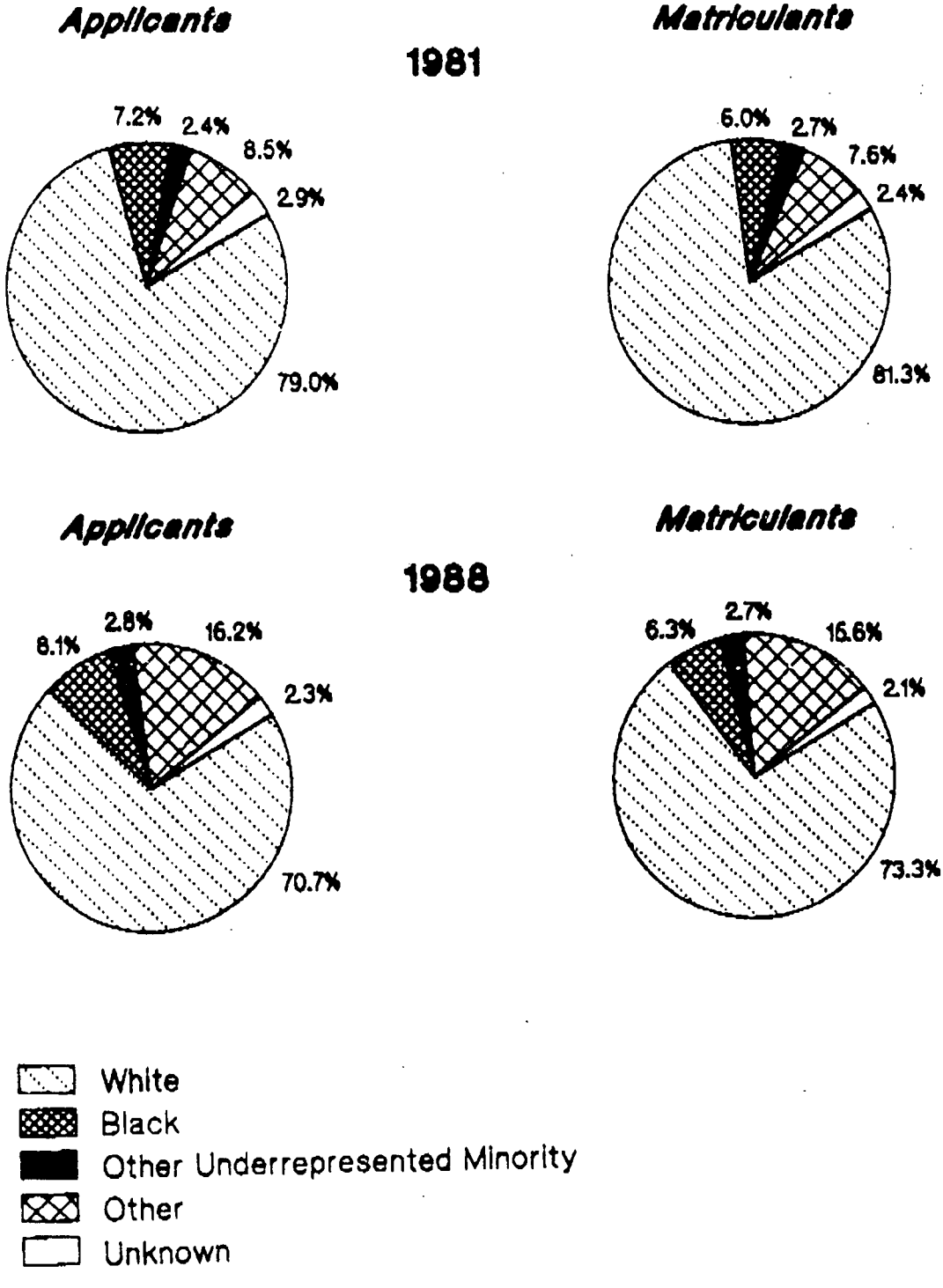


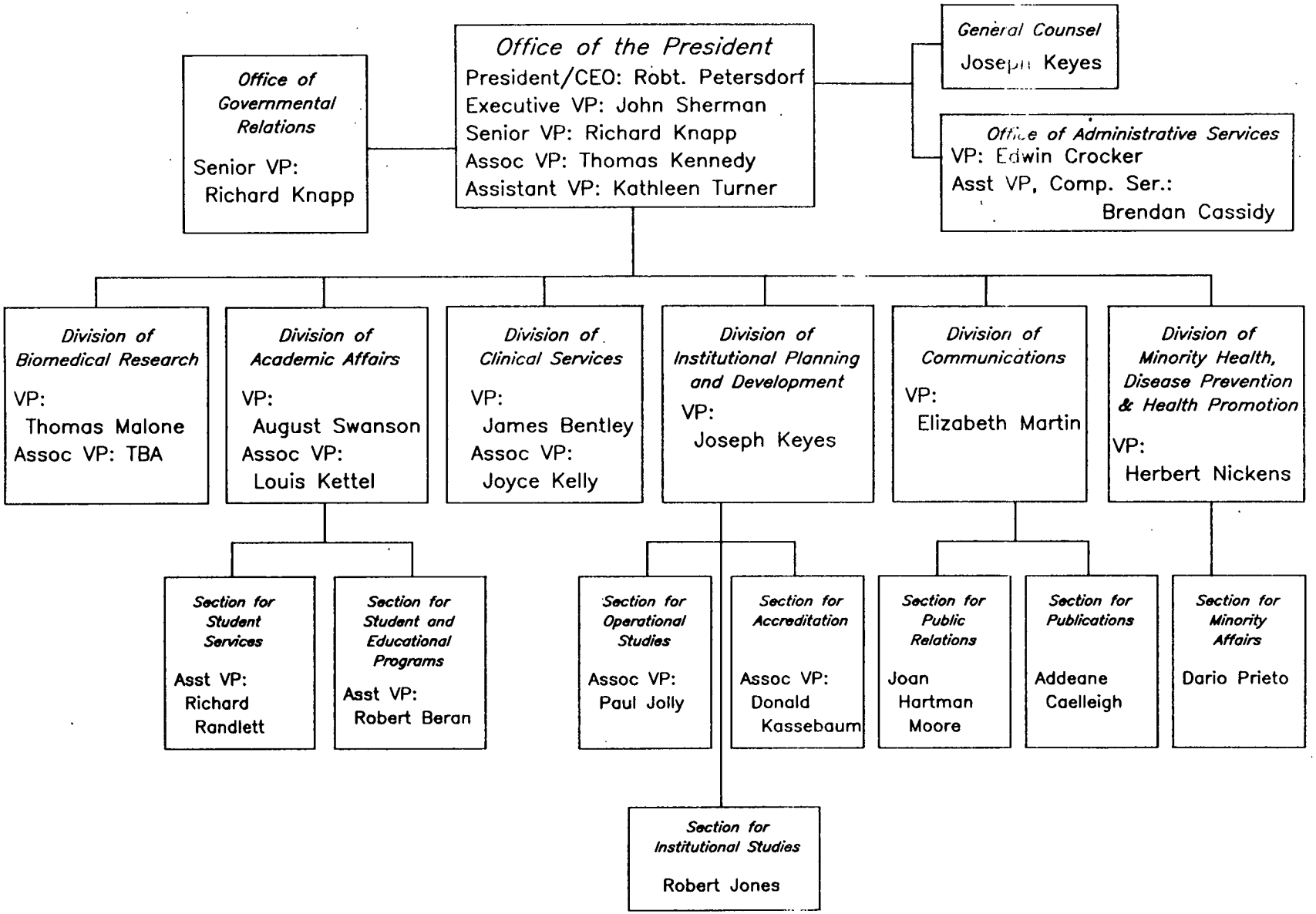
FIGURE III

Ethnicity of Applicants and Matriculants 1981 and 1988



12/01/88

AAMC Organization Chart



Association of American Medical Colleges

Council of Deans

1989 Spring Meeting

Fess Parker's Red Lion Resort

Santa Barbara, California

April 12-15, 1989

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April 6, 1989

Administrator
Health Care Financing Administration
Department of Health and Human Services
P. O. Box 26676
Baltimore, Maryland 21207

REF: BERC-142-P

"Payment for Physician Services Furnished in Teaching Settings; Payment to Providers for Compensation Paid to Physicians Who Furnish Services to Providers"

Dear HCFA Administrator:

The Association of American Medical Colleges (AAMC) is pleased to submit these comments with respect to the above referenced proposed rules, issued February 7 (54 Federal Register 5946-5971) affecting the payment for physician services furnished in a teaching setting. The AAMC represents 365 major teaching hospitals which participate in Medicare, 127 accredited medical schools; 110 faculty practice plans and 88 academic and professional societies. Our members have a strong interest in these proposed rules and are concerned about their potential impact on the practice of medicine in teaching hospitals.

The AAMC has been actively involved with the issues raised in these proposed rules for twenty years. The Association has testified before Congress, met with representatives of the then Bureau of Health Insurance, and worked with HCFA staff. As a result, the AAMC has a unique and comprehensive perspective for evaluating the proposed rules. The AAMC comments emphasize three major issues:

- the inadequacy of the definition of "teaching physician,"
- the newly proposed offset of practice plan income; and
- the proposed use of compensation related charges for physicians who do not involve residents in the care of patients.

The AAMC also raises a number of other issues for clarification and comment.

I. MAJOR ISSUES

A. Definition of a Teaching Physician.

The definition of a teaching physician, as delineated in Section 415.200 (a) on page 5963, is too broadly stated and vague:

> "Teaching physician means a physician who is compensated by a hospital, medical school, other affiliated entity, or professional practice plan for physician services furnished to patients, and who generally involves interns or residents in patient care."

The terms "other affiliated entities" and "professional practice plan" are not defined. Therefore, it is not clear which physician practice groups are included and which are excluded by the definition. For example, it is not clear how a community-based group of five physicians organized into a professional corporation (P.C.) and admitting inpatients to a teaching setting will be defined. Are the five physicians defined as "teaching physicians" because the group admits its patients to a teaching hospital or as non-teaching physicians because the P.C. receives and retains all practice fees?

For physicians admitting patients to a teaching hospital, the advantage of being defined as a teaching physician is the existence of the special customary charge rules which set a minimum fee of 85% of the Medicare prevailing. For physicians with profiles in excess of the Medicare prevailing, the disadvantage is the documentation requirements necessary to replace the 85% presumption with the full Medicare prevailing. Part of this disadvantage can be minimized by constructing a simple method, based on payer mix, for overturning the 85% presumption. The disadvantage can also be reduced by narrowing the definition of "teaching physician" to one which clearly separates physicians included in the definition of teaching physicians from those not included. Therefore, the AAMC recommends that HCFA develop a "bright-line" definition distinguishing clearly the physicans defined as "teaching physicians".

B. Offset of Practice Plan Income

As explained in the preamble and in the regulations themselves, HCFA is proposing, under some circumstances, to reduce allowable hospital costs for physician services furnished to providers "if any part of the payment a physician receives for physician services furnished to individual patients is directly or indirectly returned to or retained by the provider or a related organization under a formal or informal agreement." The AAMC strongly opposes this proposed change in HCFA policy because it:

- is inconsistent with Congressional action replacing cost-based payments for teaching physicians with charge-based payments;

- in effect, imposes compensation related charges on hospitals and physicians who did not elect this option when provided the choice;

- violates the separation between trust funds by using Part B trust funds to support Part A activities;

- expands the concept of the costs of related organizations into the area of revenues of related organizations;

- is inconsistent with Medicare's current policy of not offsetting gifts and income from endowments;

- treats various medical center arrangements differently based solely on their legal structure, and

- sets in place a policy which will diminish the incentive for physicians to assist their medical school or teaching hospital.

The AAMC strongly recommends that the disposition of a properly earned Part B fee should not affect either the amount of the fee or the costs incurred by a teaching hospital.

First, Section 948 of P.L. 96-499, the Omnibus Reconciliation Act of 1980, repealed provisions of Section 227 of P.L. 92-603, the Social Security Amendments of 1972. Section 227 provided that physicians in teaching hospitals must be paid on a reasonable cost basis for professional medical services unless the services were provided to a private patient (as defined by the Secretary) OR the hospital met the billing and collection provisions of the law's "grandfather" clause. Section 948 repealed Section 227 by providing provisions which enable a physician in a teaching hospital to bill charges for the services performed or personally supervised for Medicare beneficiaries. With this legislative action, Congress expressly replaced a provision which prescribed cost payments (Section 227) with a provision recognizing customary charge payments (Section 948). Thus, Congress intended for teaching hospitals, related medical schools and practice plans to benefit from the customary charge payments. It was and still is the intent of Congress to permit teaching physicians to charge a customary fee for services performed and to realize net income from those fees. The option to elect cost-based reimbursement remains if all physicians within an institution agree to be compensated in this way. Therefore, in reviewing Sections 227 and 948, the Association finds no legislative precedence for requiring the proposed offset of faculty practice income.

Second, Section 948 emphasized a charge-based approach for paying for teaching physicians. It allows, however, for all physicians in a teaching hospital to elect payment on a compensation-related basis. By definition, compensation-related payments do not include net income. The proposed offset of practice plan net income when reasonable charges are paid, in effect, converts a reasonable charge-based approach to a compensation-related approach. By imposing the offset, HCFA essentially overturns the financial effect of the physician's decision not to elect compensation-related charges. This is

contrary to the statute and undermines the physician's right to be paid on a reasonable charge basis. The Association believes the proposed offset is inconsistent with the philosophy and intent of Section 948 because it negates the benefit of customary charges by reducing hospital costs by the difference between customary and compensation-related charges.

Third, HCFA must further consider the proposed policy in terms of the separation of Medicare's Part A and Part B trust funds. Congress intended that each trust should finance only the services covered by its respective provisions, mandating a complete separation of funds. By imposing the requirement that Part B fees not used for personal compensation be offset against institutional costs, HCFA is proposing to use Part B funds to support Part A benefits. The AAMC believes strongly that any attempt to administer the trusts in the manner suggested by the proposed offset is contrary to the requirement that each trust fund support only its own benefits.

Fourth, the AAMC also disagrees with the way HCFA has chosen to expand the term "related organization" in the proposed rules. The related organization principle, which is properly titled the "cost to related organizations" in HCFA regulations and manuals has been developed and applied solely to define allowable cost. It has never applied to Part A revenues. Nor has the term been applied to discussion of Part B program issues because these issues have typically focused on revenue and payment concerns. Therefore, the Association believes it is an inappropriate to apply the concept of the cost of related organizations to the revenues of related parties.

Fifth, several years ago, Medicare modified its policy on gifts and endowment income to provide that both restricted and unrestricted gifts/endowment income would not be offset in determining hospital costs. The proposed practice income offset is inconsistent with the established policy for gifts and endowment income. A private attending in a non-teaching hospital can make a cash gift with monies earned from medical practice and the hospital does not have to take an offset against its costs. Under the proposal, a like amount which a teaching physician allows the institution to retain must be offset. This is clearly discriminatory against the teaching physician and the teaching hospital, and the AAMC strongly opposes this discriminatory treatment.

Sixth, medical centers and community teaching hospitals are organized in many ways reflecting both historical developments, local customs, and legal requirements. While the organizational and legal structures may vary, the operational functions and relationships are often quite similar. As a result, HCFA's proposal to determine the offset on the basis of common ownership or a misapplication of the related organization principle treats functionally similar situations in very different ways. In fact, the proposal penalizes some hospitals and schools for arrangements which predate the Medicare program itself. The AAMC believes it is inappropriate to impose the offset in a limited number of settings because of their long-standing legal relationship.

Lastly, if adopted, the offset is poor social policy. If a physician retains all fees, there will be no offset. If however, the physician allows the school to retain some fee income, Medicare payments to the hospital decrease in some cases. Thus, the benefit to the institution is expropriated by the government. The outcome of this rule will be to discourage teaching physicians from contributing a percentage of their income toward the support of their medical school or teaching hospital. This would serve only to decrease school and hospital operating revenues by encouraging physicians to retain all fee income. Having retained all fees, there would be no income to offset. In effect, Medicare expenditures would not change, institutional revenues would decline, and physicians' incomes would increase. The AAMC believes the effects of imposing the offset are contrary to the public policy of encouraging schools and teaching hospitals to develop new sources of private revenues and, therefore, opposes the practice plans offset.

The Association recognizes that the proposed offset rule is a substantial change in HCFA policy. The only prior HCFA reference we can find for a practice income offset is stated in a HCFA deposition responding to interrogatories submitted by McDermott, Will and Emery as part of the discovery process in the case of Foster G. McGaw Hospital of Loyola University of Chicago vs. Blue Cross and Blue Shield Association/Health Care Services Corporation Intermediary, May, 1985. In it's response, HCFA stated that Medicare policy considered faculty practice income, transferred from the faculty practice plan to university education and research accounts, as donor restricted gifts. HCFA stated these funds were subject to offset against the hospital's otherwise allowable clinical teaching salary costs under the provisions of 42 CFR 405.423, "Grants, Gifts and Income From Endowments" and section 607, Transfer of Funds to a Provider by Another Component of the Same Entity. The AAMC believes this HCFA deposition demonstrates that the offset currently being proposed has a new policy basis, the revenue of related organizations. While the Association strongly opposes such a policy for reasons discussed above, the new policy, if implemented, would clearly require prospective implementation only. It should not be applied to prior years to determine prospective payment rates for inpatient services or the per resident payment amount under the proposed regulations on direct medical education payments. Moreover, because the policy would be new and would not have existed at the time of the PPS and direct medical education base periods, adoption of the policy should not be used to reduce future payments by recalculating base period costs.

Payments to Physicians Not Using Interns and Residents

Under Section 948, Congress limited reasonable charge-based fees to physicians practicing in hospitals where at least 25% of the non-Medicare patients paid at least 50% of their charges. The underlying policy is that Medicare will pay reasonable charges where other patients are paying on the same or similar basis. If the patients are not paying above this threshold, compensation-related charges are imposed.

The draft regulations also propose to impose compensation-related charges where other patients are paying similar charges but where the physician does not use residents in the care of patients. This proposal is inappropriate for all teaching hospitals, but it would be especially burdensome to community teaching hospitals where all physicians may not involve residents in care of their patients. Under the regulations, a physician compensated by the institution for patient services who admits and cares for a patient without involving residents, would be paid on compensation-related charges while a physician involving residents would be paid using the special customary charge rules. The physician not using residents is disadvantaged economically when compared to either the physician in a non-teaching hospital who is paid on general reasonable charge rules or to the physician involving residents in the care of patients. There is no basis for disadvantaging the physician not using residents in this way. Therefore, the AAMC strongly recommends that where a physician in a teaching hospital does not involve residents in the care of patient, the physician should be paid using the general reasonable charge rules.

II. Other Issues

A. Personally Provided Physician Services (Section 415.170)

Intermediary Letter No. 70-7, published in January, 1970 states (in the response to question four) that "a physician qualifies for Part B payment only if he performs either: (1) activities set forth in IL372 as necessary to qualify as an "attending physician," or (2) "personal, identifiable medical services" (emphasis added). The February 7 regulations discuss extensively condition one: providing services under the attending physician provisions. There is no clear discussion of the eligibility for Part B fees for personally performed medical services, condition two. If the absence of this discussion of paying for personally performed services implies a change in HCFA policy, the AAMC opposes the change and requests that it be formally proposed in a separate Notice of Proposed Rulemaking. Otherwise, the Association requests HCFA to confirm that it still intends to pay on a reasonable charge basis for services personally provided by the physician.

B. Distinct Segment of Care (Section 415.174).

The February 7 proposed rule states a physician may qualify as a patient's attending physician if the services provided constitute a distinct segment of the patient's course of treatment and are long enough to require the physician to assume a substantial responsibility for the continuity of the patient's care. In Intermediary Letter 70-7, published in June, 1970, the example given for this policy involves a medical patient who is transferred to surgery. This is an appropriate example of a change in attending physicians when a change in clinical service occurs. A second basis for the change should also be recognized. In many teaching hospitals, attending physician responsibilities for a service rotate on either a weekly or monthly basis. For example, Dr. Smith is the attending physician in orthopedics in January. At the end of the month, Dr. Smith turns all of his patients and

his attending physician responsibilities over to Dr. Jones. This example illustrates how continuity of care in a teaching hospital is assured through assigning physicians on a rotating basis to a particular service for a distinct period of time. Patient care has been provided by two attending physicians, each provided a distinct segment of care. Continuity of care was preserved vis a vis the transfer of patient responsibility to the second physician. The Association recommends that HCFA permit a physician to attain "attending physician" status when the physician's responsibility for patients changes as a result of a formal, scheduled transfer of attending physician responsibilities.

C. Supervision Costs

Section 415.50 (a) (5) states, with respect to allowable cost a provider incurs for services of physicians, that "the costs do not include supervision of interns and residents unless the provider elects reasonable cost reimbursement as specified in Section 415.160." The AAMC notes that this rule is stated in the regulatory context of cost reimbursement elected for all physician services. Some reviewers, however, are interpreting this to mean that HCFA will disallow all supervision costs in all hospitals. The AAMC's interpretation is that this rule will not effect supervision costs under the per resident payments specified by the COBRA provisions for direct medical education costs. The Association requests verification of our interpretation of this section.

D. Presumptive Tests

The proposed regulation involves two statistical tests for physician fees. The first seeks to determine whether non-Medicare patients generally pay physician fees for personal medical services in the hospital. Under the law, Medicare fees are paid on a reasonable charge basis when 25% of the non-Medicare patients pay at least 50% of their billed physician fees. For the test, the law specifies Medicaid shall be considered full payment. In the interest of minimizing administrative costs for both HCFA and AAMC members, the AAMC recommends constructing the following series of presumptive tests:

Step 1: Payer Mix Test -- Medicaid Only.
If either the hospital or the faculty practice plan for teaching physicians can show that at least 25% of the non-Medicare patients were entitled to Medicaid, certify the hospital as meeting the 25/50 test.

Step 2: Payer Mix Test -- Third Party Payers

If either the hospital or the faculty practice plan for teaching physicians can show that the primary payer for at least 25% of the non-Medicare patients was Medicaid, Blue Shield and/or commercial insurance, certify the hospital as meeting the 25/50 test.

Step 3: Aggregate Payment Test

If the hospital or the faculty practice plan for teaching

physicians can show that fees collected for non-Medicare/non-Medicaid equal at least 50% of fees billed, certify the hospital as meeting the 25/50 test.

Step 4: 25% Payment Test

If the hospital or faculty practice plan for teaching physicians can show that the percentage of Medicaid patients plus the percentage of patients paying at least half of the fees billed exceeds 25%, certify the hospital as meeting the test.

These four steps have been sequentially designed so that a hospital meeting an earlier test would not have to furnish the more extensive data required for the later test. The AAMC encourages HCFA to adopt this approach for the 25/50 test.

The second statistical test is required by the special customary charge rules. Under the proposed rules teaching physicians are paid at the greatest of: 1) the charges most frequently collected in all or substantial part, 2) the mean of charges that are collected in full or substantial part, or 3) 85% of the prevailing charge. The billing entity has the opportunity to provide evidence supporting a customary charge greater than the 85% of the prevailing. The AAMC recommend that a simple, low cost method based on payer mix be devised for demonstrating eligibility for payments above the 85% presumption as follows:

Step 1: If the largest group of non-Medicare patients is covered by a Blue Shield plan paying charges on the basis of usual, customary and reasonable fees, declare the physician eligible for 100% of the Medicare prevailing.

Step 2: If the largest group of non-Medicare patients is covered by a Medicaid program paying charges on the basis of usual, customary and reasonable fees, declare the physician eligible for 100% of the Medicare prevailing.

Step 3: If the largest group of non-Medicare patients is covered by commercial insurance with major medical coverage, declare the physician eligible for 100% of the Medicare prevailing.

Step 4: If a majority of non-Medicare patients are covered by Blue Shield, commercial insurance with a major medical, and a Medicaid program paying at the Medicare prevailing, declare the physician eligible for 100% of the Medicare prevailing.

Step 5: If the physician can show that fees collected for non-Medicare patients equal a defined percentage of the charges billed (perhaps 60%), declare the physician eligible for 100% of the Medicare prevailing.

In all cases, because physicians are reluctant to furnish income and patient data to government auditors or agents, the AAMC recommends allowing the physician or billing group to submit a report from a licensed CPA demonstrating compliance. The tests

proposed above are designed to be applied sequentially with those meeting an earlier test not having to meet a later one.

E. The 90% Cap on Customary Charges

When the law establishing the special customary charge rules for teaching physicians was amended in 1984, the minimum payment of 85% of the Medicare prevailing was raised to 90% if all physicians accepted assignment. While this was enacted to provide an inducement to accept assignment, it may have the opposite effect. In hospitals where at least one physician does not accept assignment, the physicians can submit data to be paid up to the level of the Medicare prevailing. If all physicians accept assignment, the law appears to limit payment to 90% of prevailing. To restore the incentive to accept assignment, the AAMC wishes to work with HCFA to submit a legislative proposal providing that where all physicians in a teaching hospital accept assignments, fees would be paid at no less than 90% of prevailing charge.

F. Reasonable Compensation Equivalent Limits.

HCFA is proposing to discontinue annual review and updating of the reasonable compensation equivalent limits (RCE) on the basis that the total amount of physician compensation costs subject to the RCE limits has been greatly reduced since the advent of the hospital prospective payment system. Because publications of the information requires little effort above that necessary for HCFA to make its own annual review, the Association recommends that HCFA continue to review, calculate and publish the reasonable compensation equivalent (RCE) limits on an annual basis.

G. Anesthesiology Attending Physician Requirements

Section 415.182 proposes to revise the regulations to provide that an attending physician relationship cannot be established if an anesthesiologist concurrently directs more than two interns or residents. The AAMC supports the proposal to limit charge payment to the medical direction of no more than two concurrent cases when residents or interns are involved.

H. Outpatient Services

The proposed rules recommend modifying the attending physician criteria for services provided in all outpatient settings, including family practice and emergency department settings. The AAMC acknowledges HCFA's efforts to respond to the concerns physicians have had with the current attending physician criteria under IL-372 in the outpatient service areas. The Association welcomes these changes and regards the new criteria as essential in promoting the development of ambulatory care services in teaching hospitals.

The AAMC appreciates the opportunity to provide comments prior to issuance of a final rule on this subject. The Association would like to encourage maintaining an open dialogue with HCFA on the issues of concern discussed in this letter of comment. If HCFA

staff members would like clarification on any aspect of the AAMC's comments, please do not hesitate to contact James Bentley, Ph.D., Vice President or Robert D'Antuono, Staff Associate, Division of Clinical Services at (202) 828-0490. Thank you.

Very sincerely yours,

Robert G. Petersdorf, M.D.

AAMC OFFICE OF GOVERNMENTAL RELATIONS
CURRENT STATUS OF LEGISLATIVE & REGULATORY ACTIVITY
April 7, 1989 - 101st Congress

Changes from last week are bold and underlined
Unless otherwise indicated, all dates are 1989

LEGISLATION

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
FY 90 Budget (DM)			Reagan budget sent to Congress 1/9. Bush amendments submitted 2/9. Negotiations continue between Administration and Congressional leaders.
FY 1989 Supplemental Request (DM)	**Labor-HHS-Education and VA-HUD Appropriations Subcmtees. marked up 4/5, and rejected Administration's proposal for across-the-board cuts.**		**President submitted request 4/4. Would provide $343 million for VA medical care, $892 million to cover GSL defaults. Administration proposes to offset supplemental requests through 1.19 reduction of various domestic discretionary programs including ADAMHA, and Title VII health manpower.**
FY 90 VA Budget (LG)	Kenneth Shine, M.D. Dean of UCLA testified on the proposed VA Budget before the House VA Cmte.	VA Cmte. sent recommendation to Budget Cmte. on 2/22. Deans testified at Veterans' Affairs Cmte. hearing 3/6. VA Cmte sent recommendation to Budget Cmte. on 3/8.	House and Senate VA Cmtes. requested $1.3 billion over the Administration's FY-90 proposed budget for all medical programs.
VA Supplemental Funds for FY-89 (LG)	The House VA Cmte. requested a $520 million supplemental for VA medical programs. The VA-HUD-IA Appropriations Subcmte. held a hearing on 3/1 and forwarded a supplemental request to the full Appropriations Cmte.	Senate VA Cmte. requested a $520 million supplemental for medical programs.	Secretary-designate Derwinski requested $314 million supplemental for FY-89. **President Bush submitted this request to Congress as part of a $2.2 billion supplemental appropriations bill on 4/4. The bill includes $829 million in budget cuts to offset the spending increase.**
FY 90 HHS Appropriations (DM)	Labor - HHS Appropriations Subcmte. scheduled hearings for OASH 4/10. AAMC to testify 5/3.	Labor-HHS Appropriations Sbcmte. scheduled hearings with HHS Secretary (4/10), OASH (4/14), ADAMHA (4/18) & NIH (5/1).	
Reprogramming of $29 million in FY 89 Title VII funds (SC)			As part of the FY 90 budget proposal, DHHS proposed reprogramming $29 million in FY 89 Title VII program funds to be transfered to cover HEAL defaults. DHHS has reconsidered the need for the $29 million & does not intend to request the reprogramming.
FY 90 NSF Appropriations (DM)	VA-HUD-IA Appropriations Subcmte. held hearing 3/15.	VA-HUD-IA Appropriations Sbcmte. scheduled hearing 4/3.	

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
PPS Payments (CC)	H. Con. Res. 40 introduced 1/31 by Reps. Johnson, Oberstar, and Boxer (Ways & Means). "Resolution to Protect Medicare" companion to Senate resolution.	S. Con. Res. 10 introduced 1/31 by Sens. Simon, Kassebaum and Durenberger (Finance). Companion to House resolution.	Resolution to fund Medicare payments to hospitals at current law levels. Payment rates would fully reflect increases in costs of goods and services. 40 Senators and 229 Congressmen have cosponsored the companion resolutions.
	H.R. 1110 introduced 2/23 by Rep. Skelton (Ways & Means).		Would pay hospitals a blended rate (hospital-specific and national) relative to variation in costs within DRGs.
	H.R. 1026 introduced by Rep. Downey (Ways & Means).		Would maintain current distribution of day/cost outliers for hospital payment for 3 years.
	H.R. 130 introduced 1/4 by Rep. Collins (Ways & Means).		Would provide emergency financial assistance to Medicare hospitals.
	H.R. 1610 introduced 3/23 by Rep. Gilman (Ways & Means).		Would require annual updating of hospital area wage index factor to reflect the most current data, beginning FY-90.
Physician Payments (CC)		S. 188 introduced 1/25 by Sen. Symms (Finance).	Would eliminate caps on physician fees.
	H.R. 1271 introduced 3/2 by Rep. Slattery (Ways & Means)		Would eliminate increases in prevailing charge levels for certain physicians where such an increase would raise the prevailing charge level above the national median prevailing charge level for that service.
	H.Con.Res. 83 introduced 3/23 by Rep. Slattery (Education & Labor).		Expresses sense of the Congress regarding geographic variations in physician payments under Medicare.
"Ethics in Patient Referrals Act" (CC)	H.R. 939 introduced 2/10 by Rep. Stark (Ways & Means). Hearing conducted 3/2 by Ways & Means Subcommittees on Health and Oversight.		Providers of Medicare services would be prohibited from accepting referrals from physicians with an ownership interest or other compensation arrangement.
"Medicare Inpatient Capital Expenditure Amendments" (CC)	H.R. 712 introduced 2/2 by Rep. Stark (Ways & Means). Hearing conducted 3/13 by Ways & Means.		Would require states establish capital expenditure review plans. Review would apply to all capital expenditures over $1 million.
Mandatory Assignment (CC)	H.R. 155 introduced 1/3 by Rep. Donnelly (Ways & Means, Energy & Commerce).		Would require physicians to accept the assigned rate for Medicare reimbursement.
Patient Dumping (CC)	H.R. 821 introduced 2/2 by Rep. Stark (Ways & Means). "Medicare Hospital Patient Protection Amendment."		Would protect against improper transfer for economic reasons.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
Nursing (CC)		S. 119 introduced 1/25 by Sen. Inouye (Finance).	Would provide pediatric nurse practitioner or pediatric clinical nurse services under Medicare Part B, and would become a mandatory benefit under Medicaid.
		S. 125 introduced 1/25 by Sen. Inouye (Finance).	Would provide for direct payment under Medicare for RN's as assistants in surgery.
		S. 126 introduced 1/25 by Sen. Inouye (Finance).	Would allow nurse practitioners or clinical specialists, in collaboration with a physician, to certify or recertify the need for certain services; would also provide for Medicare coverage of services by a nurse practitioner or clinical nurse specialist.
	H.R. 1140 introduced 2/28 by Rep. Roybal. "Nursing Shortage and Nurse Reimbursement Incentive Act" (Ways & Means; Energy & Commerce).		Extend coverage and reimbursement for nursing services under Medicare and Medicaid.
	H.R. 143 introduced 1/4 by Rep. Collins (Ways & Means; Energy & Commerce).		Would permit direct reimbursement to RNs as assistants at surgery.
	H.R. 324 introduced 1/4 by Rep. Quillen (Ways & Means; Energy & Commerce).		Would permit direct payment to RNs under Medicare.
	H.R. 327 introduced by Rep. Quillen (Ways & Means; Energy & Commerce).		Would permit direct payment to LPNs under Medicare.
Physician Assistants (CC)	H.R. 1175 introduced 2/28 by Rep. Wyden (Ways & Means; Energy & Commerce).		Would provide Medicare Part B coverage for all physician assistant services not presently covered.
		S. 461 introduced 2/28 by Sen. Grassley (Finance).	Would permit Medicare payment for services of physician assistants outside institutional settings.
Catastrophic Health Insurance (CC)	H.R. 169 introduced 1/4 by Rep. Fawell (Ways & Means; Energy & Commerce).	S. 43 introduced 1/25 by Sen. Reid (Finance).	H.R. 169, H.R. 332, H.R. 864, H.R. 697 & S. 43 would repeal Medicare Catastrophic Coverage Act.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
	H.R. 332 introduced 1/3 by Rep. Ritter (Ways & Means; Energy & Commerce).		
	H.R. 697 introduced 1/25 by Rep. T. Luken (Ways & Means; Energy & Commerce).		
	H.R. 864 introduced 2/6 by Rep. McCandless (Ways & Means; Energy & Commerce).		
	H.R. 63 introduced 1/4 by Rep. Archer (Energy & Commerce; Ways & Means).	S. 335 introduced 2/2 by Rep. McCain (Finance). "Medicare Catastrophic Coverage Revision Act."	H.R. 63, H.R. 1564, and S. 335 would delay for one year the effective dates of the supplemental premium and additional Part B benefits with the exception of the spousal impoverishment provision.
	H.R. 1564 introduced 3/22 by Rep. DeFazio (Ways & Means, Energy & Commerce). "Medicare Catastrophic Coverage Revision Act."		
		S. 608 introduced 3/16 by Sen. Wallop (Finance).	Would require that catastrophic health coverage under Medicare Part B listed as a separate benefit and allow for separate election of the benefit.
	H.R. 872 introduced 2/6 by Rep Sabo (Energy & Commerce) "Comprehensive Health Care Improvement Act."		Would establish state assistance program for coverage of catastrophic health care expenses.
	H.R. 974 introduced 2/9 by Rep. Frank (Ways & Means; Energy & Commerce).		Would amend tax code and Title XVIII of the Soc. Sec. Act to finance increased benefits under the Medicare Catastrophic Coverage Act.
		S. 445 introduced 2/23 by Sen. Nickles (Finance) "Catastrophic Coverage Delay Act."	Would delay Catastrophic Coverage Act for 2 years and establish a Commission to assess health care needs of the elderly.
		S. 660 introduced 3/17 by Sen. DeConcini (Finance). "Medicare Catastrophic Coverage Refinancing Act".	Would repeal increase in Medicare Part B premium, and the supplemental premium. Would fund coverage by lifting cap on income for contribution to Social Security and Medicare trust funds, and through general revenues.
National Health Insurance/ Minimum Health Benefits/ Mandatory Health Coverage (CC)	H.R. 16 introduced 1/3 by Rep. Dingell (Energy & Commerce).		Would create a national health insurance program to be financed by payroll deductions.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
		S. 494 introduced 3/2 by Sen. Durenberger (Finance).	Would increase amount and extend for 5 years the deduction of health insurance costs for self-employed individuals.
Health Insurance Deduction (CC)	H.R. 1422 introduced 3/15 by Rep. Carr (Ways & Means). H.R. 1535 introduced 3/25 by Rep. McEwen (Ways & Means).		H.R. 1422 and H.R. 1535 would allow income tax deduction of 100% of health insurance costs of self-employed individuals.
"Hospital Indigent Care Assistance Act (CC)	H.R. 754 introduced 1/31 by Rep. Stark (Ways & Means; Energy & Commerce).		Would impose an exise tax on employer's cost of providing medical benefits to employees for support of indigent care.
Medicaid (CC)	H.R. 800 introduced 2/2 by Rep. Leland (Energy & Commerce).	S. 339 introduced 2/2 by Sen. Bradley (Finance). "Infant Mortality and Children's Health Act."	Would expand Medicaid services to pregnant women and infants to reduce infant mortality.
	H.R. 833 introduced 2/2 by Rep. Waxman (Energy & Commerce).		Would improve basic access to health care for needy children under Medicaid program.
	H.R. 751 introduced 1/31 by Rep. Stark (Ways & Means).		Would assure appropriate payment for inpatient hospital services under Medicaid.
		S. 440 introduced 2/23 by Sen. Biden (Finance) "Health Care for Children Act."	Would extend Medicaid coverage to low-income children.
		S. 614 introduced 3/16 by Sen. Paul Simon.	**Would require states to make prompt payment for medical services under Medicaid.**
	H.R. 1568 introduced 3/22 by Rep. Kennelly (Energy & Commerce) "Infant & Mortality Prevention Act."		Would provide supplemental resources to enhance the delivery of health services to pregnant women and infants, through child health service block grants.
	H.R. 1573 introduced 3/22 by Rep. Miller (of CA) (Energy & Commerce; Education & Labor).		Would improve and expand services for child health.
Rural Health Care (CC)	H.R. 762 introduced 2/2 by Rep. Pickle (Ways & Means). "Equity for Rural Hospitals Act."	S. 306 introduced 1/31 by Sens. Bentsen & Dole (Finance) "Equity for Rural Hospitals Act."	Would modify Medicare payments to hospitals by developing a single rate with adjustments. Would increase medical education demonstrations from 4 to 10. H.R. 762 and S. 306 are companion bills.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
	H.R. 1168 introduced 2/28 by Rep. Roberts (Ways & Means).	S. 10 introduced by Sen. Dole (Finance).	Would ensure that Medicare dependent small rural hospitals receive at least their reasonable costs for 3 years. S. 10 and H.R. 1168 companion bills.
	H.R. 804 introduced 2/2 by Rep. Michel (Ways & Means).	S. 205 introduced 1/25 by Sen. Symms (Finance).	H.R. 804, H.R. 880 & S. 205 would eliminate the payment differential between urban and rural hospitals.
	H.R. 880 introduced 2/7 by Rep. Craig (Ways & Means).		
		S. 227 introduced 1/25 by Sen. Moynihan (Finance).	Would exempt small rural hospitals from PPS.
		S. 366 introduced 2/7 by Sen. Baucus (Finance). "Rural Health Manpower Assistance Act."	Would make Medicare payment reforms to ensure the adequate provision of health care in rural areas.
	H.R. 1270 introduced 3/2 by Rep. Slattery (Ways & Means).		Would permit certain rural hospitals to elect to be paid on cost basis for inpatient care.
	H.R. 186 introduced by Rep. Gunderson (Ways & Means).		Would allow small rural hospitals to be paid on a reasonable cost basis.
Trauma Care (CC)	H.R. 436 introduced 1/4 by Rep. Bates (Energy & Commerce).	S. 15 introduced 1/25 by Sen. Cranston (Labor & Human Resources).	Aid to states for adopting trauma care plans set by American College of Surgeons and American College of Emergency Physicians. Would include employee guidelines with respect to infectious diseases.
	H.R. 753 introduced 1/31 by Rep. Stark (Ways & Means) "Medicare Trauma and Emergency Quality Assurance Act."		States would coordinate emergency medical services under statewide trauma and emergency care plans. Establishment of such plans would assure continued payment for Medicare trauma DRGs.
Fetal Tissue/ Tissue Transplantation Research (SC)	H.R. 1351 introduced 3/9 by Rep. Holloway & 20 cosponsors (Energy & Commerce).		H.R. 1351 would prohibit federal funding of all research that uses fetal tissue from induced abortions.
			Department's transplantation funding moratorium still in effect; NIH panel reports and DAC's recommendation to lift moratorium were forwarded to the ASH. Final decision pending.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
Animal Welfare Protection Act (LG)	H.R. 425 introduced 1/3 by Rep. Roth (R-WI) (Agriculture).		Provides increased enforcement and stricter penalties for violations of the Animal Welfare Act.
Research Accounting for Use of Animals (LG)	On 1/19, Rep. Torricelli (D-NJ) re- introduced this legislation (H.R. 560) from the last Congress (Energy & Commerce).		
Employee Benefit Non-discrimination Rules (LG)	H.R. 518 introduced 1/19 by Rep. Crane (R-IL) (Ways & Means).	S. 89 introduced 1/25 by Sen. Symms (R-ID) (Finance).	Would delay for 1 year implementation of Sec. 89.
	H.R. 634 introduced 1/24 by Rep. LaFalce (R-NY) (Ways & Means).		Would repeal application of Sec. 89.
	H.R. 692 introduced 1/27 by Rep. Henry (R-MI) (Ways & Means).		Would establish that the non-discrimination rules included in Tax Reform Act of 1986 would not take effect until the IRS issues appropriate guidelines and regs.
		S. 654 introduced 3/17 by Sen. Pryor (D-AR). Co-sponsors include 9 members of the Senate Finance Committee.	Designates as "Section 90" arrangements to simplify compliance with Sec. 89.
Tax Free Employer-Provided Assistance (LG)	H.R. 1165 introduced 2/28 by Rep. Pickett (D-VA). Would exclude from income employer-provided tuition assistance of $5250 per year for undergraduates and $1500 per year for graduate students.	S. 260 introduced on 1/25 by Sen. Moynihan (D-NY).	Would restore prior law regarding tax-free, employer-paid tuition benefits (Sec. 127 of the Tax Codes).
Deductibility of Student Loan Interest (LG)	H.R. 747 introduced 1/31 by Rep. Schulze (R-PA). Over 270 co-sponsors.	S. 656 introduced 3/17 by Sen. Symms (R-ID).	Similar bills introduced by other House members.
	H.R. 1588 introduced 3/23 by Rep. VanderJagt (R-MI) with 26 co-sponsors.		Restores the deductibility of educational loan interest for health professionals who practice in medically undeserved or health manpower shortage areas.
Foreign Medical Graduates Anti-discrimination (SC)	H.R. 614 introduced 1/24 by Rep. Bates (Energy & Commerce).	S. 304 introduced 1/31 by Sen. Moynihan (Labor & Human Resources).	Prohibits different requirements in eligibility for residency, licensure, reimbursement, etc. Makes HHS enforcer of federal licensure standards. H.R. 1134 introduced 2/27 by Rep. Solarz (Energy & Commerce). H.R. 1134 threatens Medicaid funding loss for noncompliant states.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
National Service Legislation (SC)	H.R. 660, introduced 1/27 by Rep. McCurdy (Education & Labor, Armed Services, and Veterans Affairs). Companion to S. 3.	S. 3 introduced 1/25 by Sen. Nunn (Labor & Human Resources).	Legislative intent of all bills is to promote national and community service and provide educational opportunities in exchange. S. 3 & H.R. 660 would eventually replace current federal student aid programs.
	H.R. 717 introduced 1/31 by Rep. Panetta (Education, Labor, and Interior & Insular Affairs).	S. 322 introduced 2/2 by Sen. Dodd (Labor & Human Resources). Companion to H.R. 717.	Senate Labor Committee hearings held 3/9, 3/14, and 3/20. House Education Subcommittees held joint hearing 3/15. **Another joint hearing is scheduled for 4/19.**
		S. 382 introduced 2/9 by Senator Graham (Labor & Human Resources).	
		S. 408 introduced 2/9 by Sen. Mikulski (Labor & Human Resources).	
	H.R. 948 introduced 2/9 by Rep. Kennelly (Education & Labor, Armed Services, Veterans' Affairs).		
	H.R. 985 introduced 2/9 by Rep. Morella (Foreign Affairs).		Demonstration project; Would add educational benefits to Peace Corps program.
	H.R. 1000 introduced 2/9 by Rep. Bonior (Education & Labor); Companion to S. 408.		
		S. 539, 540, 541 introduced 3/9 by Sen. Bumpers (Labor & Human Resources).	Expands loan forgiveness for service in tax exempt organization of Peace Corps or VISTA.
Stafford Student & Loan Defaults/ Restriction on Student Status Deferment (SC)	No companion	S. 568 introduced 3/15 by Sen. Pell. Approved by full Senate 3/17.	S. 568 includes a provision restricting use of student deferments by medical residents and a 5% administrative fee on SLS loans. House is awaiting Education Department's regulations and will probably not introduce a default bill.
Treatment for Mentally Ill and Homeless Veterans (LG)		S. 405 introduced by Sen. Cranston (D-CA).	Requires the VA to provide a community-based residential treatment program for homeless chronically mentally ill veterans.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
Eligibility of Care for Veterans (LG)		S. 328 introduced 2/3 by Sen. Symms (R-ID).	Requires the VA to furnish hospital care to veterans with non-service, connected disability. Nursing home care would be discretionary.
AIDS (DM)		S. 14 introduced 1/25 by Sen. Cranston (Labor & Human Resources).	Would assist eligible consortia in providing services to AIDS patients.
Nursing Research Facilities (DM)	H.R. 927 introduced 2/9 by Rep. Purcell and 26 co-sponsors (Energy & Commerce).		Would authorize $5, 10 & 15 million in FYs 90, 91, 92, respectively, for grants to "acquire, construct, improve or repair" nursing research facilities. Requires 50/50 match of federal and non-federal funds. 15% set-aside for institutions with less than $20 million in federal R&D in preceding 2 years.
Federal Salary Increase (DM)	H.R. 1132 introduced 2/27 by Rep. Morella (Post Office & Civil Service).		Would provide salary increases for members of Senior Executive Service employees, including nearly 600 SES employees at HHS.
Lyme Disease (DM)	H.R. 979 introduced 2/9 by Rep. Hochbrueckner & 15 co-sponsors (Energy & Commerce).	S. 223 introduced 1/25 by Sen. Moynihan (Labor & Human Resources).	Would provide grants for research, treatment and public education.
Patient Confidentiality (DM)	H.R. 1206 introduced 3/1 by Rep. Lightfoot (Energy & Commerce).		Would prevent PHS from disclosing to Congress, without patient's consent, patient identifying information in records acquired or created by PHS.
FDA Recruitment (DM)	H.R. 1207 introduced 3/1 by Rep. Lightfoot (Energy & Commerce).		Would assist FDA in recruiting scientists and other health professionals.
Transgenic Animal Patent Reform Act (DM)	H.R. 1556 introduced 3/22 by Rep. Kastenmeier (D-WI) (Judiciary).		Would recognize that the Patent Office has determined that genetically altered animals are patentable; would prohibit patents for humans; would define the scope of a patent on patented transgenic farm animals.
Transgenic Animal Regulatory Reform Act (DM)	H.R. 1557 introduced 3/22 by Rep. Kastenmeier (D-WI) (Agriculture and Science, Space & Technology).		Would provide a regulatory approach for the treatment of transgenic animals.

For more information, contact the AAMC Office of Governmental Relations. Individuals responsible for issues are indicated by initials following items.

CC = Catherine Cahill, 202-828-0526
SC = Sarah Carr, 202-828-0525
LG = Leslie Goode, 202-828-0526
DM = Dave Moore, 202-828-0525

REGULATION

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ANTI-KICKBACK REGULATIONS

The Office of the Inspector General of HHS issues a proposed rule to implement a provision of the Medicare Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93). The proposed rule specifies various payment practices which, although potentially capable of inducing referrals of business under Medicare, would not be considered kickbacks for purposes of criminal prosecution or civil penalties.

1/23/89 - [54 FR 3088]

Agency Contacts: Harvey Yampolsky, Office of General Counsel (202) 472-5335;
Joel Schaer, Office of the Inspector General (292) 472-5270.
AAMC Contact: Robert D'Antuono (202) 828-0493.

Deadline for comments: March 24, 1989

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DRUG-FREE WORKPLACE

Interim final rules issued to implement Drug-Free Workplace Act (P.L. 100-690). All federal grantees and contractors must certify that they will maintain a drug-free workplace as a condition for receiving federal funds. Rules become final effective March 18, 1989. OMB coordinated publication of governmentwide rule for grantees, which amends the nonprocurement debarment and suspension common rule. DOD, GSA and NASA published Federal Acquisition Circular 84-43 to amend the Federal Acquisition Regulation (FAR) for contracts over $25,000. Comments are requested on both rules.

1/31/89 - [54 FR 4946]

Agency Contacts: (Grants) Barbara Kahlow, Financial Management Division, OM, (202) 395-3053

(HHS Grants) Neil Steyskal (202) 245-0729

(Contracts) Donna Fossum, Office of Federal Procurement Policy, OMB, (202) 395-3300

or

Margaret Willis, FAR Secretariat (202) 523-4755

AAMC Contact: Allan Shipp (202) 828-0480 or David Moore (202) 828-0525

Deadline for comments: April 3, 1989

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TEACHING PHYSICIAN PAYMENTS

HCFA has issued the long awaited proposed rules governing payment for physician services in a teaching setting. The rules propose to implement statutory provisions that specify the circumstances under which physicians in teaching settings would be reimbursed on a reasonable cost basis or alternatively, on a reasonable charge basis.
2/7/89 - [54 FR 5946-5971]

Agency Contact: Kenneth Marsalek (301) 966-4502, Payment for Physician Services in Teaching Settings and Payment for Consultative Pathology Services Furnished to Patients in Providers

Ward Pleines (301) 966-4528, Payment to Providers for Compensation Paid to Physicans Who Furnish Services to Providers

AAMC Contact: Robert D'Antuono (202) 828-0490

Deadline for comments: April 10, 1989

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IRS MINIMUM PARTICIPATION STANDARDS

The IRS has issued proposed regulations relating to minimum participation standards under section 401 (a)(26) of the IRS code of 1986. The regulations will provide public guidance on the minimum participation standards affecting sponsors of, and participants in, qualified pension, profit-sharing, and stock bonus plans.

2/14/89 - [54 FR 6710-33]

Agency Contact: Nancy Marks (202) 343-6954
AAMC Contact: Leslie Goode (202) 828-0525

Deadline for written comments and requests for a public hearing: April 17, 1989

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IRS SECTION 89 NON-DISCRIMINATION REGULATIONS

The IRS issued a notice of proposed rulemaking on regulations relating to employee benefit plans under sections 89 and 125 of the IRS Code of 1986. The regulations provide guidance on the non-discrimination and qualification requirements for sponsors and participants of a variety of plan types, including accident and health plans, group-term life insurance, and dependent care assistance.

3/2/89 - [54 FR 9460-9504]

Agency Contact:
Felix Zech or David Monroe
Office of the Chief Counsel
Employee Benefits and Exempt Organizations
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, D.C. 20224
Attn: CC:CORP:T:R (EE-130-86)

AAMC Contact: Leslie Goode 828-0525

Deadline for written comments or requests for a public hearing: May 8, 1989.

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EMPLOYER-PROVIDED TUITION ASSISTANCE

The IRS issued a notice providing guidance on the proper tax treatment of educational assistance received by employees in 1988. This guidance relates to programs under Sections 117, 127, and 132 of the Internal Revenue Code of 1986, as amended by P.L. 100-647 in 1988.

3/20/89 - [Internal Revenue Bulletin 1989-12][Notice 89-33]

Agency Contact: Monica Rosenbaum (202) 343-6954

AAMC Contact: Leslie Goode (202) 828-0525

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ANIMAL WELFARE ACT AMENDMENTS

The Department of Agriculture, Animal and Plant Health Inspection Service issued a proposed rule and request for comments on a portion of the Animal Welfare Act Amendments of 1985. The proposed regulations pertain to the interrelationship between Parts 1 and 3 of the Act. Specifically, USDA intends to update, clarify and expand the list of definitions in order to inform the public on the scope of the regulations and enforce them.

3/15/89 - [54 FR 10822] [9 CFR Parts 1,2,3]

Agency Contact: Dr. R. L. Crawford, USDA, Room 268, Federal Building,
6505 Belcrest Road, Hyattsville, MD 20782
(301) 436-7833

AAMC Contact: Leslie Goode (202) 828-0525

Deadline for comments: May 15, 1989 for parts 1 and 2; July 14 for part 3.

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ESTABLISHMENT OF OFFICE OF SCIENTIFIC INTEGRITY

HHS amended its statement of Organization, Functions and Delegations of Authority to establish an Office of Scientific Integrity within the Office of the Director, NIH, to serve as the PHS focal point for coordinating scientific misconduct activities for intramural and extramural research programs, oversee scientific misconduct investigations of awardee institutions, investigate allegations of misconduct when necessary, and make recommendations

ISSUE | HOUSE STATUS | SENATE STATUS | COMMENTS

to the Office of the Assistant Secretary for Health (OASH) regarding allegations of scientific misconduct. The OASH organizational statement is amended to establish an Office of Scientific Integrity Review, with responsibility for ensuring that PHS research agencies adequately carry out policies and procedures regarding allegations of scientific misconduct.

3/16/89 [54 FR 11080]

AAMC Contact: Allan Shipp (202) 828-0480.

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MEDICAL WASTE TRACKING ACT

EPA issued an interim final rule and request for comments on the Medical Waste Tracking Act of 1988, enacted on November 1, 1988. The Act requires EPA to establish a two-year demonstration program for medical waste tracking in Connecticut, New Jersey, New York, and the seven Great Lakes States. The interim final rule specifies the procedure under which states may petition in or out of the demonstration program. It also lists the wastes identified by the EPA that require tracking and establishes regulations and standards for implementing the demonstration program. Finally, the rule requests public comment on the regulations presented.

3/24/89 [40 CFR Part II 12326]

Agency Contacts: Superfund Hotline (800) 424-9346

or

Michael Petruska (202) 382-3000
U.S. Environmental Protection Agency
401 M Street, S.W., Room S-242
Washington, D.C. 20460

AAMC Contact: Leslie Goode (202) 828-0525
Allan Shipp (202) 828-0480

Deadline for comments: May 23, 1989.

NATIONAL COMMISSIONS AND COUNCILS

Prospective Payment Review Commission (ProPAC)

ProPAC submitted its annual Report to Congress March 1. Although the reporting date required by statute is March 1, ProPAC has requested additional reporting time for the technical supplement to the report. Therefore, recommendations for changes in Medicare's prospective payment system will be conveyed to the appropriate Congressional committees March 31. The next meeting of ProPAC will be held April 18.

Physician Payment Review Commission (PPRC)

The PPRC met March 9-10. The annual Report to Congress is due April 30. Hearings to address PPRC's recommendations to Congress were held 3/17 before the Senate Finance Committee, and 3/21 before House Ways & Means. The next meeting of the PPRC will be held April 6 and 7 to review and finalize the Report to Congress.

Prescription Drug Payment Review Commission

Appointments to the Commission have been made, but staffing for the Commission will not be complete until May. The meeting schedule has not yet been established. The first Report to Congress is due May 1, 1990.

Council on Graduate Medical Education (COGME)

The Council is scheduled to meet June 1-2 and November 2-3, 1989.

Bipartisan Commission on Comprehensive Health Care

Appointments to the Commission have only recently been completed. Rep. Pepper has been named Chairman. Judith Fedder has been named staff director. Other staffing anouncements have not yet been made, although an organizational meeting was held February 28. Two reports will be prepared by the Commission:

- The Report on Comprehensive Long-Term Care Services for the Elderly and Disabled is due 6 months after the Commission first convenes.
- The Report on Comprehensive Health Care Services is due 1 year after the Commission first convenes.

There is some discussion among the members as to whether the reports should be combined, and whether or not the legislated reporting dates are appropriate.

Congressional Biomedical Ethics Advisory Committee

The Committee is scheduled to meet in May, July, September and November 1989. The May meeting has been set for May 15 and 16 in Washington, D.C.

Conclusions and Recommendations of the Committee

I. ADEQUACY OF SUPPLY

A. Conclusions

1. There promises to be an abundance of physicians in the future. As a result of the tremendous expansion of the medical education capacity over the past two decades and a substantial influx of foreign medical graduates, the number of physicians in the United States will continue to increase until the year 2020. Unless there are changes not now anticipated, the physician-to-population ratio at that time will climb to double that of 1960 (280 M.D.'s/100,000 pop.). This level is unprecedented and most observers believe that it will be more than adequate for foreseeable needs. This abundance may well place strains on the profession and challenge society's capacity to use it productively.

2. The predicted number of physicians may not constitute a surplus. Based on present knowledge, requirements for physicians cannot be reliably determined. Social policy decisions to improve care for those currently underserved, the aging of the population, a new level of commitment to public service, the addition of useful but labor intensive technologies, the emergence of new diseases requiring additional professional attention, the allocation of increased physician time to each patient, shorter work weeks, reduced career lengths, and the pursuit of new careers that appropriately use physicians' skills may, singly or in combination, prove to be appropriate uses for the projected

abundance. As the proportion of women in the profession has grown from 15% in -19-- to 40% in 19-- , we have witnessed significant changes in the character of the profession and of medical practice brought about by a single demographic shift.

3. It is possible, however, that the number of physicians could become so large in relation to requirements as to have adverse consequences for health care. The surfeit of physicians could result in adverse consequences for the quality of health care in two ways. First, it could lead to an atrophying of skills of those in practice. The need for physicians, in particular those who specialize in surgical procedures, to maintain their skills through constant exercise of them is well documented by health care services research. On this basis, Medicare regulations specify for health care institutions a minimum number of procedures to be performed in a given period in order to qualify for reimbursement. The findings of health care services research in areas related to procedures may have more general applicability. The large number of physicians projected may reduce the ratio of patients to physicians below that necessary for many physicians to practice competently.

"Overdoctoring", the provision of excessive and unnecessary services by physicians, is a second possible deleterious consequence of a surfeit of physicians. This could occur inadvertently or as a consequence of efforts by physicians to achieve target incomes. There does not now appear to be a reliable method of linking the incidence of either overdoctoring or the effects of physician skills atrophied from disuse to measures of physician supply. Yet,

there is reason to pursue the continued development of measures of physician services and patient outcomes and to be watchful for potential linkages.

4. The concerns of those who anticipate a surplus and thus argue for a reduction in the aggregate size of the entering class of U.S. medical schools deserve continuous review. Rising health care costs in part attributable to the increasing number of physicians, declining interest in medicine among those choosing careers, a disturbing level of physician disaffection with their profession, and the substantial lag between decisions on medical school class size and the impact of those decisions on the number of practicing physicians, all justify continuing attention to issues associated with physician supply.

B. Recommendations

1. To the extent that medical school class size determinations are influenced by concerns associated with physician supply, they should weigh more heavily their own assessments of local or regional requirements than any conclusions about a national surplus.

2. Indicators of "overdoctoring" should be developed and monitored. AAMC should support additional funding of the National Center for Health Services Research and other organizations engaged in this kind of activity. The problem of excessive diagnostic and therapeutic intervention is real. While it is appropriately addressed by professional self-discipline and by regulatory authority, it is potentially related to the supply of physicians. If it can be tracked with some confidence, it may offer an important signal to policy makers, on which decisions related to the supply of physicians could be based.

3. Measures of "atrophy of skills" should be monitored. It is well established that surgeons who frequently perform highly technical procedures have better outcomes than those who perform the same procedures infrequently. Numbers of operations per surgeon are currently available, but these figures should be disaggregated if possible, to the level of common highly technical procedures such as coronary artery bypass grafts or kidney transplantation. If the number of physicians performing these operations with inadequate frequency should increase, it would be a sign of a harmful physician surplus.

II. UNDERSERVED POPULATIONS

A. Conclusions

1. The number of physicians would not appear to be so much in excess of requirements if those populations in the United States whose health care needs are currently inadequately served had better access to physician services. Seventeen percent of Americans under age 65 have no health insurance of any kind. While Medicaid provides an inadequate level of services to the very poor, many of the uninsured are members of the working poor, people who are employed part-time or in less established industries which do not provide health insurance to their employees or their families. If social policy could be modified to increase the access of these populations to medical services, the abundance of physicians could prove to be a significant asset rather than a potential liability.

B. Recommendations

1. The elimination of the physician shortage should be regarded as an opportunity for society to assure adequate access to health services for all. The AAMC should work with other organizations and governmental agencies to develop durable solutions to the problem of access to care for the underserved. By emphasizing the notion of "durable solutions" the committee means to convey several concepts. It does not presume to design, in the confines of this report, the features of a system which would satisfy its expectations, but it is confident that such a system would depend neither on the charitable impulse of physicians (however worthy this may be), nor on short term incentives for physicians to practice in shortage areas (such as loan forgiveness for periods of service). Rather, the committee believes that what is required is a definitive social commitment to ensure that a basic level of health care is accessible to every member of our society.

III. MEDICAL SCHOOL CLASS SIZE

A. Conclusions

1. Class size determinations are properly institutional decisions. Medical education in this country is conducted by 127 institutions of diverse ownership, mission and character. Enrollment decisions reflect this diversity. Class size determinations must also take into account the level of student interest, as medical schools cannot admit students who do not apply. And, while all schools are, and should be, influenced by national polices, national resource

and national needs, the committee endorses the current system of diffused responsibility as preferable to a more centralized planning model.

2. Establishing physician manpower targets by specifying entering medical school class sizes is not an appropriate function for a private sector agency to perform. While it is sometimes suggested that the accrediting bodies should fill this role, the Committee concludes that the mandate of such agencies is appropriately limited to the evaluation of the quality of educational programs. National organizations with an interest in physician manpower should monitor, study and, where appropriate, recommend appropriate manpower levels. These recommendations should serve as guides to institutional and student decisions.

3. Medical schools should reduce class size rather than compromise their own standards of student quality. In making decisions regarding the size of their student bodies, medical schools should be guided by a focus on their institutional missions. However, they should be clear as to the relationship between the achievement of their missions and their own minimum standards for student qualifications. If they face a situation where the applicants available to them fail to meet their quality standards, medical schools should reduce their class size rather than compromise that quality.

4. Given the predicted abundance of physicians and a declining pool of able applicants, there appears to be no good reason for the inauguration of new medical schools or the expansion of existing schools.

IV. UNDERREPRESENTATION OF ETHNIC MINORITIES

A. Conclusions

1. The problem of underrepresentation of certain minorities in the medical profession deserves aggressive action. Substantial advances were made in the sixties and early seventies, but progress in addressing this need has been stalled for some years now. This state of affairs should be regarded as intolerable and remediable with appropriate action at all levels of the educational system.

B. Recommendations

1. Strenuous efforts should be made to reduce the under-representation of some minorities in the profession. Special emphasis should be placed on the need to attract qualified minority students to the medical profession. This effort will require not only that medical schools attempt to get their message across to able college students, but it will require as well that medical schools and the medical profession cooperate with local organizations and agencies with roots in the community. It is a high priority to persuade minority youth at an early age of the importance of learning, so that career opportunities in general are not foreclosed by premature departure from school. Because results from this approach can be achieved only in the long term, short term actions are required in the interim as well. Medical schools should renew their commitment to affirmative action in recruitment of students, admissions and academic enrichment, as well as in the recruitment of minority faculty. Program directors in teaching hospitals should increase affirmative action recruiting efforts for residency programs. The combination of these long term and short term efforts requires the continued and expanded support of federal,

state and local government programs as well as renewed support from the private foundations. Finally, the existence and seriousness of this multifaceted program should be dramatized to capture the imagination of the minority community. The reality of the commitment to remove existing financial barriers to the study of medicine by the announcement of a major new program of financial assistance would be one such symbol.

V. APPLICANTS TO MEDICAL SCHOOL

A. Conclusions

1. The intrinsic attractiveness of medicine as a profession has never been greater. While some of the business aspects of the profession are not as attractive to traditional physicians as they once were, younger physicians have been able to adjust to the new practice environment with little difficulty. Great advances in biomedical science have opened new and potentially limitless opportunities for positive therapeutic interventions, and these improved possibilities for achieving positive outcomes combine with the unchanging satisfactions of the immediate and intimate human connection a physician achieves with a patient.

2. Attracting able students should take on a high priority not only for individual medical schools but for the AAMC as well. Toward this end, the Association should consider the development of a major recruiting campaign which will provide young potential applicants and their advisers an appropriate understanding of the promise of medicine as a career. The message of any such campaign should be factual and well balanced, emphasizing the opportunity for

public service, the excitement of the new biology, unparalleled opportunity for providing help to others in need, continuing intellectual challenge and stimulation, a sense of continuous accomplishment, social respect and economic well being. The message should also include an accurate portrayal of the current practice environment, including both underrepresented specialties and underserved populations. It should also convey a realistic portrayal of the income potential in the current and foreseeable practice environments.

IV. INFORMATION AND ANALYSIS

A. Conclusion

1. Accurate and timely information will assist schools to forecast potential problems in filling their classes with able students. The ability of medical schools to make appropriate determinations of the size of their entering classes can be greatly enhanced by the provision of timely and accurate information about the characteristics of applicants who are likely to present themselves. Reports based on AAMC data allow schools to review trends in their own applicants in the context of similar institutions, region and nation. AAMC modeling efforts promise to provide schools with advance indications of the number and characteristics of applicants expected for each institution. These data are expected to be of increasing importance to the individual schools in the current time of declining interest in physician careers.

B. Recommendations

1. AAMC data collection and analytic efforts should be continued and strengthened. The rich resource which the Association's SAIMS data base

represents is now beginning to be exploited for the benefit of the local institutional decision-making. The publication of the AAMC book Trends in Medical School Applicants and Matriculants, 1978-1987 represents an important contribution. Associated with this Task Force, the Association has begun to explore the potential of various modeling techniques to inform future decision-makers of individual institutions, including projections of applicant number and characteristics at the individual school level. While these efforts are in their early stages, initial results demonstrate that they are instructive and can assist decision-makers in both preparing for and making appropriate institutional decisions.