aamc association of american medical colleges

AGENDA
FOR
COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

MONDAY, NOVEMBER 7, 1977

2 PM - 5 PM

BALLROOM EAST
WASHINGTON HILTON HOTEL
WASHINGTON, D.C.

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

FUTURE MEETING DATES
1978

COD Administrative Board ----------January 19, 1978
Executive Council ----------January 20, 1978

COD Administrative Board ----------March 23, 1978
Executive Council ----------March 24, 1978

COD Administrative Board ----------June 22, 1978
Executive Council ----------June 23, 1978

COD Administrative Board ----------September 14, 1978
Executive Council ----------September 15, 1978

COD SPRING MEETING
Snowbird, Utah

April 24-27, 1978

COUNCIL OF DEANS
ANNUAL BUSINESS MEETING
November 7, 1977
Ballroom East
Washington Hilton Hotel
Washington, D.C.

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
SPRING BUSINESS MEETING

Wednesday, April 20, 1977
8:30 a.m. - 12 Noon
Sonora B
Scottsdale Hilton Hotel
Scottsdale, Arizona

MINUTES

I. Call to Order

The meeting was called to order in Executive Session at 8:30 a.m. by John A. Gronvall, M.D., Chairman.

II. Quorum Call

Dr. Gronvall announced the presence of a quorum.

III. Consideration of Minutes

The minutes of the November 12, 1977 Annual Business Meeting, held at the San Francisco Hilton Hotel were approved as submitted.

IV. Chairman's Report

A transcript of the Chairman's Report follows:

"The chairman's report to you will be mercifully brief. I want really to say only two things. One, to encourage you to complete the evaluation form about the Spring Meeting. The Spring Meeting format was altered a number of years ago and the informal feedback that we have had and such formal feedback as we have gotten in the way of letters and so on has been positive, but it was thought very wise this year to conduct a somewhat more systematic analysis. It would be helpful to Julie Krevans and the people who will be planning next spring's meeting if you would conscientiously take a little time and fill out the questionnaire.

The only other thing that I want to comment on is in a sense a continuation or an expansion of some comments that I made in San Francisco regarding the evolution of the Association and my view, at least, of the developing degree of diversity in the interests of the schools in the Association and the way that we should live with that and deal with it.

It is, I think, fascinating that at a time when the country seems determined on the idea of enforcing a higher degree of uniformity, regulations, rules and guidelines on the schools that the schools themselves are working harder than ever to become diverse and to develop diverse kinds of programs. It seems to me that the diversity of the schools represents an enormous national strength and, in fact, is one of the best contributions that the medical schools can make to the country, by being diverse, by adapting their programs and goals to the needs of the society that supports them, as each school sees it.

This, of course, creates problems for an organization such as the Council of Deans or the broader Association, the entire Association itself, as it attempts to represent these interests. The Association, I think, is posed then in a very difficult interface between a group of very diverse institutions and an external series of publics, constituencies, governmental groups, who are increasingly expecting the schools to fall in line, to be consistent, to fall into neat categories and to have programs that are constrained by federal law, by rule and regulation. I believe that this interface position is causing duress in the Association, in the Congress when the Association cannot, in fact, speak with a single voice, for all of the schools, and when the schools have different interests, the schools themselves express discontent with a policy or position adopted by the Association which does not please them or achieve total support of all the constituent schools.

I point this out not to lecture the point or harrangue the point, but mostly in the hope that recognition of this as a difficult issue will make our deliberations on controversial issues more effective. I think the manpower legislation is a splendid example where there are strongly diverging views held by people in this room as to how we should handle that kind of difficult issue.

From my own standpoint, it seems that what we need to do is work as hard as we possibly can through the Association to insure that we have free, open and full input into the deliberations of the Association, that we then finally do have to take positions on things. Those positions will not necessarily be supported by all the schools, but the Association then does not serve to stifle the individual school, in its own program developments, or in its own relationships with its own legislature or with the U.S. Congress or other external groups. I believe that if we all recognize this as a problem, are willing to face it openly and deal constructively and openly with it, in fact, the Association can become even stronger than it is now and can continue to adequately represent the needs of very diverse institutions as we deal with the public and the government.

V. President's Report

The President's report appears as an attachment to these minutes.

VI. Report of the AAMC Finance Committee

Mr. Charles B. Womer, Chairman of the Committee was on hand to report and discuss the deliberation of the Finance Committee with the Deans.

The committee is charged with looking after the long term financial health of the Association. At its March meeting it examined: 1) the preliminary budget for the AAMC for the year beginning July 1, 1977; 2) income and expense projections through fiscal year 1980, and 3) an analysis of income by source and historical trends of income and expense. The committee concluded that the Association is currently in good economic health and should remain so through the next fiscal year. However, it will likely be near the break even position in the year beginning July 1, 1978 and move to a deficit position in the following fiscal year. The deficit would range from $250,000 to $500,000 depending on the inflation factor used in projecting expenses. These projections are based on a continuation of existing programs with no additions or reductions since the finance committee is strictly limited to finance and not program review, the latter responsibility being vested in the Executive Council.

It was the consensus of the committee that the AAMC should consider a modification of its dues structure for the year beginning July 1, 1979. Medical school dues now in effect were established in 1969 and hospital dues in 1973. Current medical school dues are $2,000 per year plus a service fee of one-tenth of one percent of the institution's operating expenses between two and 10 million dollars. The maximum dues and fees combined, therefore are $10,000 for schools with operating expenses in excess of $10 million.

There is little room for growth in the Association's income from dues since only 15 member schools have operating expenses of less than $10 million, the remainder are thus paying maximum dues.

It was further the consensus of the committee that we should seek to develop a dues structure that is responsive to inflation or deflation over a period of time, based upon some formula or index so that dues might increase or decrease in modest amounts, based upon economic conditions. This would avoid infrequent significant increases of large amounts, something the committee considers unpalatable, and in this regard I should also point out that the

present rules require an extended parliamentary process, for even modest changes in dues and fees. The committee requested AAMC staff to begin to analyze alternative approaches to our problem.

This is a preliminary report of the committee's preliminary thinking. There is no concrete proposal to offer at this time, but the committee wanted to bring this matter to the deans' attention at the earliest possible time.

Comments from the deans indicated a recognition of the potential necessity for raising dues, the alternative of reducing existing programs, and the desirability of adopting a bylaw change which would "index" the dues on the basis of an inflation factor rather than establishing a set figure which could be modified only by a long legislative process. A related comment addressed the concern that the multiplicity of programs and activities of the Association's Group on Student Affairs and other groups represented a substantial cost to the institution both in terms of time lost and in travel expenses incident to these activities.

VII. Health Manpower Legislation - P.L. 94-484

In November 1976, the Council of Deans passed a unanimous resolution deploring the intrusion into the academic prerogatives of the university represented by the provision of this legislation regarding U.S. students attending foreign medical schools. The Council clearly directed the staff and leaders of the Association to pursue vigorously with Congressional representatives the elimination or revision of this portion of the bill.

Dr. Bennett brought the Council up to date on the work of the Association in this regard. He stated that there was every reason to believe that there is a growing willingness to reconsider and that, in time, there will be a bill which could be supported.

Dr. Challoner urged that the deans not sit idly, but individually contact their Congressional representatives to express their concerns about the existing legislation.

VIII. Installation of the Chairman

Dr. Gronvall installed Dr. Julius R. Krevans as Chairman of the Council of Deans for a term extending from April 20, 1977 to November 1978. Dr. Krevans expressed his gratitude to Dr. Gronvall for the contributions he made as Chairman of the Council for the past 18 months.

IX. Communicating with Congress

Periodically the AAMC alerts deans of the need for contacting their Congressional delegation in support of or in opposition to contemplated legislation. The response has often been disappointing. We have been informed on several occasions by Congressional staff members that the absence of communications from our members has substantially weakened our prospects on important legislative and appropriations issues. At the last Administrative Board Meeting (March 1977), this matter was discussed with the conclusion that it should be made a discussion item at the Spring Meeting. Three aspects of the topic emerged:

1) The need for persuading the deans of the importance of making their views on major issues known by personal contact, letter or telegram.

2) The need for the AAMC to be informed of the contacts made.

3) The need for an appropriate structure for the alerting and feedback processes.

We are able to keep the deans informed of routine legislation through Deans' Memos, articles in the Weekly Activities Reports and sometimes mailgrams. If a crisis arises during subcommittee action, staff can telephone selected deans who have members of their state serving on the subcommittee in order to provide input to the Congress. Our problem lies in the fact that we have no effective and economical method of alerting all of the deans of an urgent and immediate problem, such as a veto override attempt, which quite often occurs within 24 hours of the veto.

For several years, there has existed a loosely structured telephone network involving members of the Group on Public Relations. The Association staff will call the national officers of the Group with legislative information and a request for possible action by the schools. In turn each officer would place five calls and each person would then place another five calls until, in theory, the message has been spread over the country. This has not worked well. The Council of Academic Societies has a similar network called a "Cascade". It is difficult to determine how well this system works.

If the GPR Network is to continue, there is a need to refine it so it becomes more effective and that it includes a mechanism for reporting back to AAMC the results of the efforts, so a head count of Congressional members can be kept. It is suggested the following be done:

1) A mechanism for the GPR member to consult with the Dean to determine appropriate action.

2) Identification with the Dean of the appropriate individuals such as board members, administrators, faculty, alumni, to assist in contacting the congressional delegation.

3) Selection of the communication method--telegram, telephone, or personal contact--depending on the time constraints.

4) Develop a means for documenting the number and content of the communiques sent by the institution's representatives.

5) Report the action taken by the academic medical center and the nature of the Congressional reaction to the AAMC so a master count can be kept to evaluate the effectiveness of the effort.

The Association sought the deans' advice as to whether the network should be abolished, or kept and strengthened. The AAMC asked advice on whether the GPR is an appropriate mechanism for such an activity, or if there is a better way of quickly communicating with the deans.

In the discussion which followed it was determined that the deans prefered the message to go to their offices, rather than the Public Relations offices and that the dean's Executive Secretary was the best person to receive the message.

It was decided that the AAMC would send a questionnaire to each of the dean's offices requesting the necessary information and would then arrange the telephone network.

X. AMA Section on Medical Schools

Each dean received a letter inviting them to attend or designate someone to attend the meeting of the new AMA Section on Medical Schools. At the March Administrative Board meeting, the general feeling was that the AAMC or the COD should not take any official position with regard to participation in that body.

Because a number of Council members expressed concern about the background and intent of the establishment of this Section, it was placed on the agenda for general discussion.

The members of the Council presented a variety of views regarding the Section. Some viewed it as an appropriate means of facilitating AMA consideration of medical educators' concerns; others felt it was inappropriate for the professional organization to begin to represent medical education. Several indicated their concern about

the additional costs entailed in sending additional persons to additional meetings. No action was taken by the Council.

XI. Implementation of P.L. 94-484

Mr. Robert Knouss, Director of Medicine of the Bureau of Health Manpower was on hand to discuss the implementation of P.L. 94-484. He described in detail the current approaches to the problem posed by the special assurances for the schools of medicine in the capitation provisions.

The deans expressed their great appreciation for Mr. Knouss's work in clarifying for the Council this very important issue.

XII. Adjournment

The meeting was adjourned at 12:30 p.m.

REPORT OF THE PRESIDENT
TO THE COUNCIL OF DEANS

April 20, 1977

I really want to talk about several matters this morning that I think are of great concern to the Association and its constituency. Among these are the issues that are likely to dominate the national agenda for the next several years, some selected issues from the current legislative scene, communications with the Congress, the new Congressional budget process as illustrative of some of the problems in communication with the Congress, and finally, a discussion of the concept of capitation as a method of support for the medical schools. You have had passed out to you a paper which outlines what we consider to be the major issues confronting the academic health centers, and I want to go over those briefly with you. These were prepared originally for a discussion that we had with Joe Onek, who is assistant director of the Domestic Council in the White House, who will have as a part of his responsibilities the areas of health in relationship to the activities of the Domestic Council. This was considered by the Executive Council, some additions were made and we do think that this probably outlines the major things that we are going to have to work on over the near term.

One of the general issues is communications with administration officials. We have, in the past, and fortunately now with having two former members of important councils of this organization in positions of high authority in HEW, we anticipate no problem in continuing to communicate with both Chris Fordham and Bob Derzon on a very informal and effective basis. We have already had contact with them and we think that this kind of interchange will be very important in developing Administration policy. We are going to spend a lot of time on the Administration. We are also very concerned about the academic and financial integrity of the academic medical centers. We have brought this to the attention of a number of people in the Administration and the Congress. One of the principal discussion items with Joe Onek was the fact that we simply cannot tolerate this yo-yo support for programs from the federal government. The academic medical centers no longer have the reserves to permit them to respond to the kind of up and down funding which we may have been able to handle better when we weren't in such tight financial conditions.

He was very appreciative of having this brought to his attention and said that through the Domestic Council he would certainly do everything that he could to try and evaluate actions that came out of the various parts of the Administration on the impact on the academic medical center.

John Sherman and a group met with Stuart Eisenstadt, who is the Director of the Domestic Council. This was also brought to his attention and he was also appreciative of the problems that medical schools and the teaching hospitals have suffered from this situation in the past and is also interested in working on this matter.

We also talked at great length with both of them about intrusion into academic prerogatives and the fact that the federal government is making it difficult for the medical schools to accept some of the programs, which have been promulgated by the Administration and the Congress.

With regard to teaching hospitals and teaching physicians, of course, the main thing that is going to confront us in the immediate future is the attempts at cost containment, which obviously will be coming at us very quickly. The Administration has a bill which will probably be introduced in two weeks. It is a bill, apparently, that they feel will serve as a basis for discussion of the issues in the Congress. I don't think that they believe that it is the final form of the legislation that will be passed. We have just obtained a copy of the bill and are studying it, it has for us many imperfections. We will be working closely with the AHA in trying to get a final bill which is as acceptable as possible.

Our real problem here is the fact that in talking, let's say with Joe Onek, he said, "you know, if you really wanted to reduce the escalating prices of health care, and felt that you had to do it, how could you do it in the short term other than putting the cap on?" And it is very difficult to come up with any alternatives. The question is, whether you really have to control the rising costs as much as some people in the Administration think we need to. But we will be working very much on that area over the next few months. Probably something may happen before the adjournment of the Congress for the August recess, or possibly if there is a lot of controversy, it may go over until they come back in September.

The report of our citizen's committee on cost containment has been very effective and many of our citizen committee members have used that very effectively in communicating with the Congress and with others about their concerns on cost containments and its effect upon the teaching setting.

We, of course, have talked here about the problems of reimbursement of graduate medical education in terms of restricting expenditures for health and I do not think I need to talk about that anymore---this morning.

We are, of course, concerned with the house officers being considered employees and the Thompson Bill; I will talk a little bit more about that later.

On manpower legislation, the AAMC task force has not yet been appointed. We have about two years yet to come up with an Association position. The reason we have not appointed this task force is we have been completely immersed in trying to do something with our present bill. We have been working with the Administration on regulations and working with the Congress on some of the aspects of this bill which are not acceptable to the

constituency -- or which are not felt to be appropriate intrusions of the Congress into our activities. So that is the reason we have not appointed that task force. It will be appointed by the time of the next Executive Council meeting in June.

I will talk a little later about viability of capitation with regard to manpower legislation in the future. We are terribly concerned with student assistance. The manpower bill does not provide the amount of funding that really is needed for the support of our students. The Guaranteed Student Loan Fund, we have shown very conclusively as a result of discussions with bankers around the country, is not going to be a substitute for the direct loans that we have had in the past. Bankers simply are not interested in those loans under the conditions under which they have to make the loans to the students.

We are working and we have had some special meetings with members of the Congress and the Administration on just the matter of student assistance.

The Health Planning Act has been renewed. Nothing has been done, essentially, in the one-year renewal that is in the process of going through the Congress now. We have talked with Mr. Rogers about our concerns on the Planning Act, and particularly the input of academic medical centers into the executive committees of the HSA's. It appears around the country, from our survey, that most of the academic medical centers have been frozen out of executive committees of the HSA's. They are on these large councils of 140 to 200 people, which meet infrequently and do little business. So we are trying to work with Mr. Rogers in the revision of the law a year from now, to mandate where a medical center is present in the HSA, to have an individual from that center represented on it. Whether we will be successful, I do not know.

In the matter of biomedical research, of course, there are continuing pressures to reduce the support for investigator-initiated research, there is more and more effort to have managed research and to extend and expand the NIH function in two areas, which we think will have serious consequences on its real mission, which is research. And we are terribly concerned when we hear that the NIH should take cognizance over the health care delivery system, a bill that has been introduced by Mr. Waxman, from California, which would have the NIH taking responsibility for assuring that the health care system is operating effectively and efficiently. We think that would destroy the NIH and its real functions.

We are also concerned about the support of young scientists and, in turn, the supply of those in academic medicine in the future, particularly for the clinical years where we have a study and a paper in which we have pointed out that we think, under the changing situation, with regard to opportunities to do research and get support, far fewer young people are interested in considering careers in academic medicine. We think this will have serious impact upon our institutions in the near term.

We are also concerned about data bases. A lot of policy is being made today on the basis of completely inadequate data. And we do think that we must work with the federal government and other organizations to begin to get a coordinated data base which will really help us make better plans on the need for numbers of physicians and for the kind and distribution of the physicians. There has been a chronic malnutrition of the National Center for Health Statistics, which has not permitted it to gain the kind of data which we think is needed in all of this.

We are, with our task force on continuing education, continuing to look at the matter of this area of growing importance, and ways to validate some of the current assumptions about the impact of continuing medical education on quality of care. We are actively supporting cognitive research and evaluation of this area.

Now, with regard to the final item on the list that was passed out, depoliticalization of the National Advisory Councils, we think there is some evidence that this is indeed occurring. It will never be completely depoliticized, but we do think we are returning to a more rational approach to the Advisory Council and committee system. Unfortunately, there is a move now to reduce substantially, as you have probably seen, the number of advisory councils and committees to the NIH, and we think this would have a very serious impact on the quality of research. The present councils and study sections are really doing about as much as they can do to review proposals and so on. If you cut the number back, they certainly cannot pay the proper attention to evaluation equality, which has been an important part of making NIH the great institution that it is. So we are going to have some discussions about that with the Administration.

With regard to legislation, I am going to limit my remarks this morning to new legislative matters of concern to us, because I think in the Weekly Activities Report and in other communications we have talked about many of the older issues of which many are still with us. There are a number of basic statutory authorities which are about to expire and the Congress to make a thorough study is extending them for only one year, with modest increases in the appropriation ceilings. These are well on their way to enactment and we see no problems with them. The National Cancer Act, the National Heart and Lung Act, etc.

The extension of these bills does carry with it a series of technical amendments, the Health Manpower Act, and what these in general do is make some modifications in the Federal Insured Loans Programs, for health professional students, the exceptional needs scholarship program, the leakage calculation in regard to primary care residencies, which in the original act would have severely penalized the schools if we ever had to pull the national trigger and have individual schools meet the requirements for

primary care residencies. It also establishes clearly the start date for the USFMS transfer provision to 1978. There has been confusion whether it is 1977 or 1978, the bill clearly designates 1978. That buys a little time for us.

And also the pool of positions that are being distributed is expanded to include those who complete programs in the U.S. two-year schools. There have been many of the schools that have to transfer students at the end of two years that have pointed out to the Congress that their students may be frozen out of third year positions if the school is forced to accept USFMS's in preference to U.S. schools.

We have, as we will talk about later, taken every opportunity we can in response to the directives of this body and the Executive Council to point out to the Congress the inappropriateness of the USFMS transfer position. We have pointed out to them the almost impossibility of implementing the provision as it stands regardless of the principles.

With regard to the Thompson Bill, we are a little more hopeful about defeating that bill now than we were two weeks ago. I would urge you to do everything you can to get letters in, to Mr. Thompson and Mr. Erlenborn as we have asked you. Numbers of letters are as important as the contents of the letters. We do want you to do everything you can to get residents who are sympathetic with our position to state that the PNHA is not representing the house staff of the country.

Of course, that bill is supported by the AMA, PNHA and AMSA; the AHA joined with us in a very vigorous protest against the bill. I was on the stand, almost two hours, in a very hostile environment, being questioned by Mr. Thompson. We did get a second hearing, set through the minority members of that committee and, hopefully, we will have a more balanced presentation of the issues as a result of the minority side being able to bring on board witnesses which can oppose the bill.

We will consider later in this agenda the matter of your communication with the Congress. This comes up as a natural consequence, let's say, of the Thompson Bill, which is the immediate concern we have. I just want to point out that this time, your group in Washington can do certain things in working with the Congress, but the real, effective work comes from their constituency. They are much more interested in knowing what their constituents think about issues than they are a national view of the issues. So, I would urge you to respond to requests for communication with your Congressman. I think it is important not only to communicate with them when you want them to do something, but when they are home, try to get them out to the medical center, get them involved with audiences that they can talk to, try and get some pictures taken that can be in newspapers, health is a very non-political area, which is of great assistance to them as they try and get their constituencies to re-elect them. If they get this kind of exposure, they are appreciative of it and will respond more.

Congress is highly responsive to the deans. They are very important constituents. You are held in extremely high regard and I would urge you to use that little extra effort to communicate with them when there are issues of great concern to us. We will be talking about mechanisms for immediate action later on in the program.

One of the things that there appears to be some uncertainty about is the new budget process in the Congress for appropriating money. We have had a lot of phone calls on the basis of our concerns about the budget ceilings for FY-78 appropriations. I would just like to point out to you that we have a two-tiered system now in the Congress and the budget committee actions limit the amount that the appropriations committees can appropriate for various programs. It is important for us to get the budget committee ceilings as high as possible so that the appropriations committees when they consider individual appropriations have some leeway and room to appropriate adequate amounts of funding. They are, supposedly, controlled by the ceilings set by the budget committee and that ceiling is set on the basis of the budget committee looking at total expenditures and total income, federal expenditures and federal income, and the assignment of the expenditure levels to various programs as they decide upon priorities. We are in the so-called 550 function, which includes health. Unfortunately, in that function we have both the uncontrollable Medicare and Medicaid expenditures, as well as the so-called controllable expenditures of support for manpower, research and so on.

We have not been pleased with the reaction of the budget committee to the controllable 550 part of that budget. They have been so concerned with the Medicare and Medicaid expenditures that they, obviously, feel that they are going to take some of those expenditures out of the controllable part of the 550 function.

And, so I think it is important for us, from now on to pay as much attention to the budget committee activities as to the appropriations committees and I would urge you, again, to work with us on that to try and convince them that we cannot live with some of the recommendations made by the members of those committees. John Sherman, who is president of the Coalition for Health Funding, which brings in a large group of organizations who work together on fiscal matters, federal fiscal matters, has been effective in increasing the budget over the requests of the chairman, however, the level of $9.1 billion for the controllable items in the 550 budget will not be achieved this year and we probably will end up with some place around 7.6 or 7.8 billion dollars which is higher than we had for the FY-77 budget, but it is certainly not enough to provide the levels of capitation and research support that we feel would be optimal.

With regard to capitation, at this time, I only want to say that I think the health manpower task force is surely going to have to examine whether capitation is the best approach for federal support of undergraduate medical

education. The original concepts of a federal share of the cost of operating our programs, our educational programs, is sort of falling by the wayside because of the strings placed on capitation. It is no longer merely a support program, it can really be looked upon as a group of special project grants tied together in a package and given to the schools on the basis of the number of students they have. Not related to the needs for support of the schools to implement the programs that are in the package. And so, now that the concept is being warped, I think this health manpower committee is going to have to look very carefully at how is the best way for us to get federal support for undergraduate medical education. And it would, I think, be very helpful to that task force if any or all of you would write in any of your recommendations on other approaches or your views on capitation for them to have when they begin their deliberations on this very important matter. We certainly will have to look for substitutions for capitation, among other alternatives for federal support.

I will speak very briefly about the LCME. You know we were challenged by the FTC, largely on the basis of the AMA's participation in accreditation of undergraduate medical education. The hearings were held before the Advisory Committee to the Office of Education on accrediting agencies and in spite of the FTC's effort, the Advisory Committee is going to recommend to the Commissioner of Education that the term of the LCME be extended for two years. That, unfortunately, is half of the usual term, which is given in reconsidering accrediting agencies the term is four years, but it does appear that this committee was brought to the point of having to examine the criteria that they are using in approving accrediting agencies and the autonomy and the participation of organizations in accreditation. We think that many of the allegations made by the FTC are groundless. However, there are some parts of that concern of the FTC that will certainly influence the views of the Advisory Committee and probably the Commissioner of Education on the whole matter of accreditation.

Finally, I would like to say to you that we are foreseeing more and more difficulties with our VA medical school affiliations. The service organizations are beginning to question whether there is real value in the relationship between the VA and the medical schools with regard to providing health care for the veterans. There are many allegations made that we are more concerned with teaching and with research, and less concerned with the veteran and that he or she is not getting the kind of care that they deserve under the VA medical care program.

I think it is very important for you, at your local level, to try and interact with the service organizations, the Veterans of Foreign Wars, the American Legion, the Disabled Veterans and others, to try and convince them of the great value of this affiliation for both sides and to try and dissuade them from some of the views that they have about what is happening

to the veteran patient in the VA hospital. Because I think we are facing a real crisis here. We have been working closely with Bill Mayer on this and we will be working with these organizations and with the VA central office on the matter at the national level, but I think it is important for you to do everything you can on the local level.

Thank you.

ELECTION OF PROVISIONAL INSTITUTIONAL MEMBERS

The following schools have received provisional accreditation from the Liaison Committee on Medical Education and are eligible for membership in the AAMC:

Texas A & M University
College of Medicine

East Carolina University
School of Medicine

Northeastern Ohio Universities
College of Medicine

RECOMMENDATION

The Executive Council recommends to the Assembly that the schools listed above be elected to Provisional Institutional Membership in the AAMC contingent upon approval by the full Council of Deans.

ELECTION OF DISTINGUISHED SERVICE MEMBER

The following individual has been submitted by the Council of Deans for consideration for election to membership status with the AAMC:

Andrew D. Hunt

RECOMMENDATION

The Executive Council recommends to the Assembly that the individual listed above be elected to Distinguished Service Membership status in the AAMC. This recommendation is contingent upon endorsement by the full Council of Deans.

REPORT OF THE NOMINATING COMMITTEE AND ELECTION OF OFFICERS

The Nominating Committee of the Council of Deans consisted of:

John M. Dennis, Chairman
Thomas A. Bruce
D. Kay Clawson
Lawrence G. Crowley
Allen W. Mathies, Jr.

The committee solicited the membership for recommendations of persons to fill the available positions by memorandum dated April 7, 1977. The returned Advisory Ballots were tabulated and the results distributed to each committee member. The committee met by telephone conference call on May 26, 1977. Dr. Dennis' letter report (dated July 21, 1977) of the committee's recommended slate of officers follows.

UNIVERSITY OF MARYLAND
BALTIMORE, MARYLAND

VICE CHANCELLOR
FOR HEALTH AFFAIRS

July 21, 1977

Julius R. Krevans, M.D., Dean
University of California,
San Francisco
School of Medicine
Third and Parnassus
San Francisco, California 94143

Dear Doctor Krevans:

Since my report as Chairman of the Council of Dean's Nominating Committee on July 5, 1977, changes have had to be made in the slate as proposed at that time. With the nomination of Dr. John Gronvall to be Chairman-Elect of the Assembly, the Council of Deans are allowed another representative on the Executive Council. The COD Nominating Committee met again at 3:00 p.m. EDT on July 19, 1977 by telephone conference call.

This letter constitutes my report as Chairman of the Council of Deans' Nominating Committee to you as Chairman of the Council of Deans. The committee met at 4:00 p.m. EDT on May 26, 1977, by telephone conference call. At that time we had available to us the tallies of the advisory ballots submitted by the Council of Deans.

The following offices will be filled by vote of the Council of Deans. The slate proposed by your Nominating Committee is as follows:

Chairman-Elect of the Council of Deans:

Christopher C. Fordham, III, M.D.
Dean, University of North Carolina
School of Medicine

Member-at-Large of the Council of Deans:

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

John Eager Howard Hall/655 W. Baltimore Street/Baltimore, Maryland 21201/(301) 528-7410

The following offices are filled by election of the Assembly. Consequently, the slate proposed for the Assembly's consideration will be developed by the AAMC Nominating Committee of which I am a member. Thus, these names will be submitted in the form of a recommendation from our Nominating Committee to that Nominating Committee.

Chairman-Elect of the Assembly:

John A. Gronvall, M.D., Dean
University of Michigan Medical School

Council of Deans Representatives to the Executive Council:

Stuart A. Bondurant, M.D., Dean and Presidnet,
Albany Medical College

Neal A. Gault, M.D., Dean
University of Minnesota Medical School

Steven C. Beering, M.D., Dean
Indiana University School of Medicine

Richard Janeway, M.D., Dean
Bowman Gray School of Medicine

(to fill, for a full-term, the seat left vacant by the death of Dr. Stetson)

These nominations, I believe, accurately reflect the wishes of the members of the Council of Deans. I am confident that we have a slate which will contribute to the work of the Association.

Thank you for the opportunity to serve in this capacity.

Sincerely,

John M. Dennis, M.D.
Vice Chancellor for Health Affairs
Dean, School of Medicine

JMD:jah

cc: Thomas A. Bruce, M.D.
D. Kay Clawson, M.D.
Lawrence G. Crowley, M.D.
Mr. Joseph Keyes
Allen W. Mathies, Jr., M.D.

INPUT INTO RETREAT AGENDA

During the second week in December, the Chairmen and Chairmen-Elect of the Councils and the Chairman and Chairman-Elect of the Assembly, will meet with selected AAMC staff to discuss AAMC activities and plan the Association's programs for the coming year. Areas of concern which members of the Council of Deans believe should be called to the attention of the Association officers should be brought up during the discussion of the Retreat Agenda. The Annual Report of the Association, which has been distributed to you, provides information regarding Association activities during the past year.

aamc association of american medical colleges

June 9, 1977

Executive Council
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

The Task Force on Student Financing is pleased to transmit the following interim report of its findings and initial recommendations to the Executive Council.

In the fall of 1977 approximately 16,000 students will enter medical schools in the United States to pursue studies that will lead to the awarding of an M.D. degree. They will join another approximately 42,000 students already enrolled in school. As many as two-thirds of these students may need financial assistance from sources other than their savings, the earnings of their spouses and help from their parents to pay for the cost of their medical education. This first report by the AAMC Task Force on Student Financing paints a gloomy picture of the likelihood that medical students will be able to find the funds they need from traditional sources of financial support.

The availability of financial assistance has changed dramatically in the past few years due to rapidly rising costs which have increased the demand for financial assistance and to changing federal policies which have served to limit the supply of financial aid. The reasons for these changes are discussed in more detail in the report; the outcome of these events warrants immediate attention because a continuation of existing trends will increasingly limit access to medical school by poor or financially disadvantaged students.

This is a trend that can be reversed. The dollar cost of additional aid is clearly outweighed by the benefits to a society cared for by practitioners of medicine representative of society and not drawn exclusively from families with large personal financial resources.

Sincerely,

The Task Force on Student Financing

Bernard W. Nelson, M.D., CHAIRMAN
Associate Dean - Academic Affairs
University of Wisconsin Medical Shcool

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

James W. Bartlett, M.D.
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J. Robert Buchanan, M.D., President
Michael Reese Hospital and Medical Center

Anna C. Epps, Ph.D.
Director, Medical Education
Reinforcement and Enrichment Program
Tulane University School of Medicine

Mr. William I. Ihlanfeldt
Dean of Admissions
Northwestern University

Thomas A. Rado, Ph.D.
Class of 1977
University of Arkansas

John P. Steward, M.D.
Associate Dean for Student Affairs
Stanford University School of Medicine

Robert L. Tuttle, M.D., Dean
The University of Texas Medical School

Glenn Walker, Ph.D.
George Washington University
School of Medicine and Health Sciences

Association of American Medical Colleges

TASK FORCE ON STUDENT FINANCING
INTERIM REPORT - JUNE 1977

Table of Contents

Association of American Medical Colleges

TASK FORCE ON STUDENT FINANCING
INTERIM REPORT - JUNE 1977

Introduction

The Association of American Medical Colleges Task Force on Student Financing was established in February 1976. The charge to the Task Force is as follows:

> The work of the AAMC Task Force on Student Financing is to be to analyze how medical students are actually financing their educational costs, to examine existing and potential sources of financial aid to medical students and to present recommendations to the AAMC Executive Council. In carrying out its work, the task force is to look at student aid mechanisms which have been experimented with both in this country and abroad and to seek the advice and counsel of government officials, economists, and members of the AAMC National Citizens Advisory Committee who represent private industry and banking. The task force is asked to present its final report to the Executive Council within two years. In its final report the task force should consider recommendations which may be directed toward the medical schools, the federal government, state and local governments, foundations and other institutions in the private sector. Because of the immediate importance of the issues with which the task force is concerned, it is hoped that interim reports will be presented to the Council.

Since June 1976 the Task Force has held five meetings. This first interim report provides information about the findings to date of the Task Force and makes recommendations which we believe warrant the immediate attention of the AAMC Executive Council. This report also provides the broad outlines of a new federal loan program for medical students as proposed by the Task Force.

The Task Force has been gratified by the participation of individuals from the government and the private sector in its deliberations. A wealth of information about how medical students currently finance their education as well as information on the availability of financial aid resources for medical students have been brought to the attention of the Task Force. Three studies deserve special mention because they contribute heavily to the findings of the Task Force. These studies are Survey of How Medical Students Finance Their Education 1974-75, prepared by the AAMC;[1] "A New Era in Medical School Finance 1976-80," by Michael Koleda and John Craig of the National Planning Association;[2] and a report issued by the Congressional Budget Office in August 1976 entitled, "The Role of Aid to Medical, Osteopathic, and Dental Students in a new Health Manpower Education Policy."[3] These three reports are highly recommended for anyone interested in more detailed information on student financing than can be covered in this report.

The Task Force study of medical student financing has been undertaken

at a time when the direction of federal policy for support of medical education, and medical students in particular, has been in a state of flux. With the enactment of the Health Professions Educational Assistance Act of 1976 (PL 94-484), the general direction of federal policy became clearer, although many of the detailed regulations for these policies will not be available until late 1977 or early 1978. Major uncertainties remain at this time about the effectiveness of these policy changes both for the immediate future as well as for the long term.

Finally, it should be noted that the Task Force has attempted to emphasize in its findings the general conditions that exist nationally. There are major differences among schools regarding how they are financed and among states in terms of their willingness to provide direct financial support to the medical schools and financial support to the students. The schools themselves have variable access to University sources of financial support. Local circumstances may minimize some of the findings in this report or may create financial aid problems for some medical students much more severe than one would anticipate from national data.

Financial aid policies for medical students are basically controlled by the federal government. These policies should be broad in their design with sufficient flexibility to recognize the difference in how schools are financed, thus ensuring that students have the widest possible choice in selecting the school they wish to attend. The Task Force recommendations are made with this concern in mind.

Findings

1. THERE IS A SHORTAGE OF FINANCIAL AID FOR MEDICAL STUDENTS ENROLLED IN MEDICAL SCHOOLS IN THE UNITED STATES. THE FINANCIAL AID SHORTFALL IN 1977-78 IS ESTIMATED TO BE $21 MILLION.

2. THE FINANCIAL AID SHORTFALL WILL HAVE ITS GREATEST IMPACT ON THOSE STUDENTS WITH LIMITED ACCESS TO PERSONAL OR FAMILY FINANCIAL RESOURCES.

3. THE PRINCIPLE FACTORS AFFECTING THE FINANCIAL AID SHORTFALL, ITS IMPACT ON ECONOMICALLY DISADVANTAGED STUDENTS, AND ITS EVENTUAL RESOLUTION ARE:

   A. A SHIFT IN FEDERAL POLICY AWAY FROM GRANTS AWARDED ON THE BASIS OF FINANCIAL NEED AND DIRECT FEDERAL LOANS AWARDED ON THE BASIS OF FINANCIAL NEED TOWARD GRANTS WITH SERVICE OBLIGATIONS NOT AWARDED ON A NEED BASIS AND PRIVATELY FINANCED LOANS GUARANTEED BY THE FEDERAL GOVERNMENT.

   B. A RELUCTANCE ON THE PART OF PRIVATE LENDERS TO PROVIDE CAPITAL FOR FEDERALLY GUARANTEED STUDENT LOANS.

   C. MINIMAL IMPACT OF EXPANSION OF SCHOLARSHIP PROGRAMS WITH A SERVICE COMMITMENT UPON THE FINANCIAL AID SHORTAGE.

   D. UNREALISTICALLY LOW BORROWING LIMITS SET FOR MEDICAL STUDENTS IN

PRESENT LOAN PROGRAMS.

4. INCREASING DEBT BURDENS WILL CREATE INCREASINGLY SERIOUS REPAYMENT PROBLEMS FOR PHYSICIANS DURING THE POSTGRADUATE YEARS.

5. THE PROPOSED FEDERALLY GUARANTEED LOAN PROGRAM FOR HEALTH PROFESSIONS STUDENTS CONTAINED IN THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976 (PL 94-484) DOES NOT APPEAR TO BE A VIABLE PROGRAM TO MEET STUDENT LOAN NEEDS.

Recommendations

A. Short Term

(1) The Task Force recommends that the Health Professions Student Loan Program be funded at the levels authorized in PL 94-484 of $26, 27, 28 million for Fiscal Years 1978, 79, and 80.

This recommendation is made in view of the impressive evidence that there exists a serious shortfall in the amount of financial aid available to support medical students in 1977-78. Furthermore, even if the new Federal Guaranteed Loan Program for Health Professions Students created in PL 94-484 could be implemented in time to provide students with needed funds, which appears unlikely, the Task Force has learned that the private money markets are highly resistant to the development of new federally sponsored loan programs. (Long Term Recommendation (1) below proposes a loan program which, since it incorporates the most effective features of existing programs, is thought by the Task Force to be a more attractive concept for all concerned than the new program in PL 94-484.)

Although substantial funds have been committed to the existing Health Professions Student Loan Program and are available to reloan to current students as repayments from previous loan recipients are received, the Health Professions Student Loan Program is meeting today a significantly lesser percentage of student need than ever before. The Health Professions Student Loan Program fund has not been able to keep pace with the rapidly increasing costs of attending medical school nor the rapidly increasing enrollment in medical schools which has more than doubled since the loan program was first funded. The loan program needs continued infusions of capital if it is to hold its own as a major source of assistance to medical students. An equally important fact is that many new and developing schools have not developed a capital fund for the Health Professions Loan Program of any significant magnitude since they have been eligible for support for only a few years.

(2) The limits on the amounts that may be loaned to medical students under the existing Guaranteed Student Loan Program should be immediately increased on a one-time basis for Fiscal 1978 from $5,000 annually to $10,000. The lifetime maximum should be increased to $20,000.

This recommendation is made because it appears highly unlikely that the

new government Guaranteed Loan Program for Health Professions Students will be inaugurated in time to insure that students enrolling in the fall of 1977 will have access to these loan funds. Because the amounts actually loaned under any federal guaranteed loan program depend on the willingness of the lender to make such funds available, the full $10,000 is not likely to be available to all students who can justify loans of that magnitude. The enlarged existing Guaranteed Student Loan Program may meet only a fraction of student needs, but when the full amount is available, it may make the difference between a student enrolling or failing to enroll in medical school.

(3) The funding for the new Scholarships for First Year Students of Exceptional Financial Need should be increased, and the program should be expanded to include second year students of exceptional financial need.

Under this new scholarship program enacted as part of PL 94-484, students of "exceptional financial need" (as yet undefined) are eligible for one year only to receive awards equivalent to tuition, fees, and books plus a monthly stipend of $400. The program is due to become operational in October, 1977. However, even at maximum authorized funding, the program would fund less than 10% of the approximately 16,000 first year medical students alone, and in fact some of these funds are also to be made available to students in the other MODVOPP fields.

With the elimination of the Health Professions Scholarship Program, this new federal scholarship program will be the only significant source of federal grant support with the exception of Armed Forces Health Professions Scholarships and National Health Service Corps Scholarships, both of which require a service commitment from recipient students and neither of which is targeted for students from low income families.

Experience has shown that students from financially disadvantaged backgrounds may have initial difficulty in adjusting to the academic demands of medical school. We therefore recommend that grant support for such students be extended to include the first two years of health professions education. After two years, the likelihood that medical students will complete their studies and then receive the M.D. degree are high. After two years the students can accept substantial loans with the confidence that they can be repaid from future earnings.

(4) Medical Schools should be encouraged to work with the American Medical Association Education & Research Foundation (AMA-ERF) to expand the capability of local banks to make AMA-ERF guaranteed loans.

The past reluctance of medical school financial aid counselors to recommend AMA-ERF as a source of loan funds has been based on concern about what were relatively high interest rates charged by the participating banks. These interest rates (currently about 9%) are now equivalent to or less than the loan rates that would be charged by the new federal guaranteed program. Although the AMA-ERF program was originally designed to be a last resort source of financial aid for medical students, the Task Force has learned that AMA-ERF can acquire the resources to expand its program and that the major banks currently

participating as lenders would be willing to assist new lenders with the establishment of local AMA-ERF loan programs. AMA-ERF should be encouraged to increase the amounts they will loan on an annual basis (currently $2,000 per year) to at least $5,000 per year. In addition AMA-ERF should be encouraged to loan to students whose debts exceed $20,000, which they presently do not, since a majority of students with financial need will soon have debts of this magnitude.

(5) Because of increasing dependence upon private capital markets as sources of financial support for medical students, medical schools should develop better relationships with lending agencies in order to help their students secure access to loan funds.

The existing Guaranteed Student Loan Program is an important source of financial support for medical students. During 1976 the federal annual and lifetime borrowing limits for medical students were increased to $5,000 and $15,000 respectively, although in some states, state guarantee agencies have set lower limits. In many instances, however, students are routinely unable to obtain whatever full amount is authorized by law. The medical schools need to work with local banks to encourage them to lend the full amount. We believe that the banks will respond favorably to requests by the schools for lending at maximum limits, particularly if the schools maintain an active interest in facilitating the processing of loans and their eventual collection.

(6) Counseling of medical students and prospective medical students about the realities of student financing and expected future incomes should be improved.

Circumstances change. The individuals who counsel students about the various mechanisms for financing their education and the costs relative to future incomes have a difficult task. Particular attention should be focused on providing students from economically disadvantaged backgrounds with such information. The Task Force believes that workshops supported by the AAMC to help train these counselors will improve the quality of advice to students and help to insure that students have knowledge of all available funds.

Such workshops also help to improve the administration of financial aid programs by providing the counselors and administrators of financial aid programs with knowledge of workable systems in place at other schools. Finally, there is a continuing need for financial aid officers to keep in touch with the rapidly changing regulations that govern implementation of federal programs. In the past, misunderstandings by the medical schools about the purpose and conditions of making grants under the Health Professions Scholarship Program were used as arguments against continuation of this program.

B. Long Term

(1) The AAMC should endorse the establishment of a new Guaranteed Student Loan Program for medical students.

The following program attempts to incorporate the more desirable features of the new Federal Guaranteed Loan Program For Health Professions Students and the existing Guaranteed Student Loan Program. The model presented is based upon the assumption that it is difficult to justify federal subsidies to underwrite the cost of medical education because of the high expected earnings of physicians. At the same time it is quite clear that as the price of attending medical school increases, it will be extremely difficult for students to borrow to meet the cost of their education and pay the interest while they are in school. The alternatives are either to accrue and compound interest or to provide an in-school interest subsidy. The Task Force proposes a program which would provide an interest subsidy paid by the federal government while the borrower is in school but limited to students who can demonstrate financial need.

Briefly, the program as proposed would have the following characteristics:

1. To assure the availability of capital, there would be a government guarantee to the lender.

2. Schools, financial institutions and states could be lenders under the program. The Student Loan Marketing Association (SLMA) would provide the source of funds either in the form of a forward commitment or as a secondary market.

3. Such a program would parallel the present Guaranteed Student Loan Program to ease administration and eliminate confusion.

4. Maximum debt for medical students would be $50,000 related to the total cost of education. Borrowing could not exceed $10,000 in any 12-month period.

5. The interest rate would be the same as that under the existing Guaranteed Student Loan Program including the special allowance (which is an amount in addition to the student interest paid by the federal government to the lender).

6. Students having a demonstrated financial need would qualify for a federal subsidy of full interest while in school and during the one-year grace period. Students without demonstrated financial need who elected to borrow would pay full interest from the point of disbursement. In both cases repayment of principal would be deferred.

7. Unlike the Guaranteed Student Loan Program, there would be no special allowance subsidy during the repayment period.

8. The interest rate would float quarterly as under the present Guaranteed Student Loan Program.

9. Repayment of principal for all borrowers would begin one year after graduation from medical school.

10. There would be a fixed graduated repayment option offered to the

borrower. Also, the number of years in pay-out would be based upon the size of the debt, e.g., a ten-year pay-out for a $15,000 debt; a 15-year pay-out for a debt of $15,000 to $25,000; and a 20-year pay-out for a debt of $25,000 or more.

11. There could be provision for deferral of interest, which would be accrued and compounded, for students engaged in advanced study who do not have access to sufficient income to make the interest payments.

12. There would be a finance charge of up to 1% deducted from the loan at the point of disbursement.

The Task Force is in the process of refining the characteristics of the proposed program. When that is completed, the Task Force believes that the proposed loan program should be reviewed by representatives of the private banking community, and of SLMA. Recommendations from these interested parties should be sought before any attempt is made to legislate such a program. This recommendation is made in view of the Task Force's findings that the new Federally Guaranteed Loan Program for Students in the Health Professions was written into PL 94-484 without such consultation. Prior consultation might have eliminated many of the undesirable features of this program and insured the development of a loan program with strong support from the medical schools, the banking community and the federal government.

(2) The Task Force does NOT recommend the development of a loan program with repayment contingent upon income.

The Task Force has devoted one full meeting to a review of income contingent loans. Such loan programs are inherently complex in their administration and costly to operate in their initial phases. Experiments with income contingent loans in the private sector have not been encouraging, and interest at the federal government level in supporting such programs has waxed and waned. The Task Force believes that the alternative proposed immediately above would provide the necessary capital and can be implemented relatively easily, and at the same time offers an option for minimizing repayment problems which is more satisfactory than the income contingent loan concept.

Background for Task Force Findings

The availability of loan or grant funds to medical students from either private or public sources for meeting the expense of attending medical school is of recent origin. The first national program of financial support was established by the American Medical Association (AMA) in 1961. This program, sponsored by the Educational Research Foundation (ERF) of the AMA, works with local banks and guarantees the loans that are made to medical students and to residents in training. Prior to the development of the AMA-ERF loan program, sources of financial support for medical students were restricted to the funds the student was able to obtain from personal or family resources or from the limited funds

available at some medical schools. The AMA-ERF loan program was followed by the development of the federally supported Health Professions Student Loan Program in 1963 and the Health Professions Scholarship Program in 1966. The funding of federal programs has followed a roller-coaster pathway reflecting changing political support for the programs. Nevertheless, these federal programs have constituted the major source of sustained grant support at most schools and an important source of loan support for medical students at all schools. In recent years the existing Guaranteed Student Loan Program (GSLP), also known as the Federally Insured Student Loan Program (FISL), in which the capital for loans is provided by the private banking sector or through state loan agencies rather than by the federal government, has grown to become the single most important source of financial aid for medical students.

The dominant role of the federal government in providing financial support for medical students is illustrated in Table 1 which shows sources of financial support for medical students in 1975-76. It should be noted that of the total aid received in 1975-76 by students (approximately $148 million), the Health Professions Student Loan Program and the existing Guaranteed Student Loan Program constituted in excess of $56 million, or over one-third of the support available to medical students.

Although both of these programs are the result of federal government initiatives, there are important differences in the sources of the money for the loans made to the student. The Health Professions Loan Program is a form of direct student loan program. The capital for the loan is obtained from a federal appropriation. The funds are administered by the school and repayments by past borrowers are available to relend to students enrolling in medical school. The initial federal contribution becomes a revolving fund. Any interest payments made by the student are added to the revolving fund and can in turn be loaned to students.

The current Guaranteed Student Loan Program, which is available to all post-secondary students, relies upon a source other than the federal government for the capital that is loaned to the student. The sources of the capital are either lending agencies such as private banks, or in some instances, state agencies which obtain the needed capital through borrowing or through a direct appropriation of funds from state revenues.

Under the current Guaranteed Loan Student Program, the government provides guarantees that the lender will be repaid the principal in case of death, default or disability by the borrower as well as agreeing to pay all or part of the interest on the loan. During the period of the time the student is in school, the interest payments on the loan are paid to the lender by the federal government if the student's family income does not exceed $25,000 and/or certain other conditions are met. This subsidization of interest has been an important benefit for the student borrower, albeit costly to the government.

Ceilings on the amount of interest that can be charged by the lender and on the amounts (both annual and lifetime) that a borrower may obtain under the Guaranteed Student Loan Program are established by federal legislation.

Table 1

Sources of Loans and Scholarships for Medical Students, 1975-76

Grant or Scholarship Funds	Amount
Health Professions Scholarships	$ 1,863,373
Robert Wood Johnson Foundation Scholarships	1,314,417
School Funds	15,068,178
Other Scholarships	7,868,606
Armed Forces Health Professions Scholarships	21,012,672
PHS/National Health Service Corps Scholarships	16,624,949
Physician Shortage Area Scholarships	2,051,522
National Medical Fellowships	1,700,134
Subtotal Grants and Scholarships	$ 67,503,851
Loans	
Health Professions Student Loans	$ 20,077,418
Robert Wood Johnson Foundation Loans	1,006,213
School Funds	6,373,045
Other Loans	7,300,391
AMA-ERF Loans	5,926,143
Guaranteed Student Loans	40,598,818
Subtotal Loans	$ 81,282,028
Total	$148,785,879

Source: Journal of the American Medical Association, December 27, 1976, Vol. 236, No. 26.

Because the lender under the Guaranteed Student Loan Program usually has several options as to whom funds will be loaned, it is not surprising that the availability of such funds to the borrower will reflect market conditions, with loans difficult to obtain when market interest rates are high and money is "tight." Lenders' willingness to lend is also influenced by their experience with the borrowers and with the federal agencies with which they must interact to collect interest or to obtain repayment when the loan is defaulted by the borrower.

In an effort to minimize some of the problems faced by the institutions lending to students under the Guaranteed Student Loan Program, the Student Loan Marketing Association (SLMA) was created by Congress in 1972. SLMA is a private, for-profit, federally chartered corporation whose purpose is to increase the volume of loans made available through the federal guarantee mechanism by improving the liquidity of the capital market for student loans and hence to increase the amount of loan funds that will be made available to students.4

In recent years government policy has shifted from direct loan assistance for medical students to loan programs in which the federal government's role is to provide guarantees to private lenders. This trend is dramatically illustrated by the student assistance provisions of the Health Professions Educational Assistance Act of 1976 (PL 94-484). The Act authorizes miminal funding for and places new restrictions on the direct federal support of the Health Professions Student Loan Program and repeals the Health Professions Scholarship Program. At the same time, the Act establishes a new Federally Guaranteed Loan Program for Health Professions Students.

Under this new Federally Guaranteed Loan Program, students may borrow up to $10,000 each year (with an aggregate borrowing limit under the program of $50,000) from private sources with repayment guaranteed by the government. In sharp contrast to existing guaranteed student loan programs, the interest due on the loan each year, including those years during which the student is enrolled in medical school, is to be paid by the student. The interest rate, which is not to exceed 10% per year plus 2% for loan insurance, is fixed annually by the Secretary of the Department of Health Education and Welfare and is not subsidized by the federal government. The student borrower under this legislation is prohibited from discharging his/her obligation to repay the loan by declaring bankruptcy within five years of the date repayment is scheduled to start. (The constitutionality of this provision has been questioned.) Specific provisions in the legislation have been made to encourage SLMA participation in the program. The shift away from a direct loan program to one in which the capital is provided by the private money market illustrates a continuing effort by the government to minimize the impact of health professions student assistant programs on the federal budget. The requirement that students pay interest while in school is traceable to the widely held view that any federal subsidization of medical student costs is unjustified because of the high future earning capacity of physicians.

Another goal of PL 94-484 is that medical services should be available in rural and inner-city areas in the U.S. which are currently underserved. The principal means to achieve this goal is the National Health Service Corps Scholarship Program under which students "repay" the government for financial assistance by practicing in physician shortage areas. PL 94-484 authorizes a

significant increase in funding for this program. The concern of the Congress that an insufficient number of students would accept scholarships under these terms if an attractive alternate means of student financing were available appears to have motivated a stipulation that access to the Federally Guaranteed Loan Program for Health Professions Students is limited to 50% of the students at each medical school. Table I makes clear that scholarships with service commitments already constitute a significant proportion of the funds reported as student aid. The actual amounts received can be expected to increase significantly in future years.

In summary, the federal government has been the principal source of funds to assist medical students in meeting the expense of attending medical school. The programs now in existence are of relatively recent origin. The trends in government policy have moved in the past two years to programs that will emphasize reliance upon the private money market as a source of capital for student loans and to programs of direct financial assistance in which the recipient is obligated to provide service in return for the aid received.

Discussion of Task Force Findings

1. There is a shortage of financial aid for medical students enrolled in medical schools in the United States. The financial aid shortfall in 1977-78 is estimated to be $21 million.

According to Koleda and Craig, the financial aid shortfall is not a problem of insufficient funds in any absolute sense, but rather is a function of the distribution of the available funds. Because not all funds are distributed based upon a recipient's needs, an "aid gap" of $21 million is estimated for 1977-78. Koleda and Craig cite several trends which underlie this aid gap:

1. The proportion of medical school aid monies comprised of scholarships with service commitments -- i.e., National Health Service Corps or Armed Forces Health Professions Scholarships -- has increased from 6% of the total available aid monies in 1972-73 to 36% in 1975-76.

2. The counterpart to the growth in scholarships with service commitments has been the phasing out of non-service committed grants and reductions in non-service committed loan funds supplied directly by the federal government.

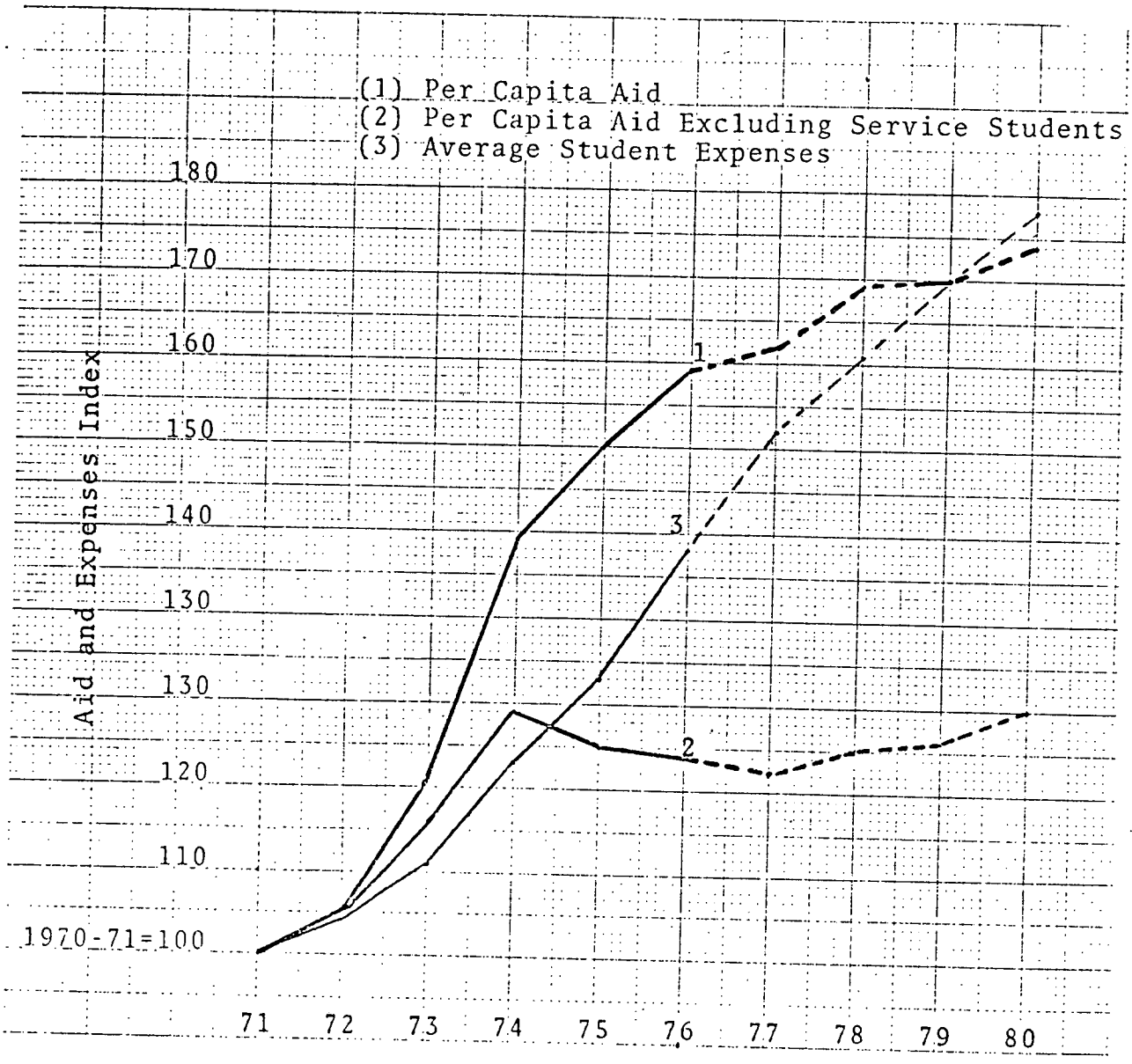
3. Capitation support to medical schools is likely to either fail to increase or to continue its downward trend with the result that tuition will maintain its upward trend. By 1975-76, tuition at medical schools had increased 66% from its 1972-73 level.

4. Although service grants comprised 36% of available aid monies in 1975-76, only 12% of the medical students held these scholarships.

Figure 1 from Koleda and Craig illustrates the problem. Using 1970-71

FIGURE I

MEDICAL SCHOOL PER-STUDENT AID AND EXPENSES, 1971-80
(Indexed to 1971 Dollar Value Base)



Source: Calculations based on data in "How Health Professions Students Finance Their Education", Division of Manpower Intelligence, BHRD, DHEW, October 1973, and on responses to annual medical surveys conducted by the AAMC.

as their base year, a year in which they saw no overall financial aid gap for medical students, they estimate that financial support funds have grown more rapidly than have student expenses. However, since a major portion of these funds are distributed without regard to financial need, and since the need-based forms of aid have not kept pace with average student expenses, a financial aid gap has resulted.

2. The financial aid shortfall will have its greatest impact on those students with limited access to personal or family financial resources.

The financial aid shortfall is illustrated by AAMC data for the years 1963-64, 1970-71, and 1974-75. From 1963-64 to 1970-71 the proportion of students depending upon family gifts and loans decreased. Between 1970-71 and 1974-75 this relationship was reversed. The proportion of students reporting gifts or loans from their families increased from 54% in 1970-71 to 64% in 1974-75. During that same period, the proportion of students receiving grants or non-family loans decreased. The data also indicate that these trends affect more seriously the economically disadvantaged student. From 1970-71 to 1974-75, the proportion of medical students from families with incomes below $15,000 declined from 52% of enrollment to 35% of enrollment. The most significant decrease was in the $5,000 to $9,999 family income group where the share of total enrollment declined from 20% to 11%. The largest gain in the share of total enrollment was in the $25,000 and over group which increased from 22% to 37%.

3. The principle factors affecting the financial aid shortfall, its impact on economically disadvantaged students, and its eventual resolution are:

A. A shift in federal policy away from grants awarded on the basis of financial need and direct federal loans awarded on the basis of financial need toward grants with service obligations NOT awarded on a need basis and privately financed loans guaranteed by the federal government.

The major change in federal grant policy from unrestricted grants to scholarships with service obligations has been described.

Important changes have also occurred in the area of student loans. There has been a growing dependence on federal or state guaranteed student loans. In 1970-71 guaranteed loans accounted for only 28% of borrowed funds but by 1974-75 they accounted for 46% of borrowed funds. Health Professions Loans on the other hand, became less important by 1974-75 having dropped, on a per capita basis, below the 1967-68 level.

B. A reluctance on the part of private lenders to provide capital for federally guaranteed student loans.

Guaranteed loan programs require the participation of private lenders. Yet private lenders are sufficiently disaffected from such programs to make their continued participation on any signif-

icant scale very doubtful. Their main criticisms of guaranteed loan programs have been of unprofitable interest rates, high default rates, inability to quickly settle claims with guarantors, and administrative complexities, especially with the present Guaranteed Student Loan Program. Furthermore, private lenders are also wary of students contracting a high level of debt. These problems with the current Guaranteed Student Loan Program are clearly such that they will prevent any growth in the program unless corrected.

The importance of correcting problems related to guaranteed student loans is demonstrated by the fact that as other aid funds have failed to keep pace with rising costs, medical students in increasing numbers have turned to guaranteed loans as much as possible to balance their budgets. In 1970-71 only 10% of all medical school students received guaranteed loans. By 1974-75, the number of medical students receiving guaranteed loans increased to 30%. The total volume of guaranteed loan funds increased by more than 200% in that same period.

C. Minimal impact of expansion of scholarship programs with a service commitment upon the financial aid shortage.

Expansion of the National Health Service Corps and/or the Armed Forces Health Professions Scholarship Programs is likely to have little impact upon the financial aid gap. As Figure I shows, total student assistance funds have kept pace with rising costs to medical students. However, service scholarships have been the major growth item, and they are not awarded on the basis of the financial need of students, nor is the size of the individual award varied with individual need. Each such scholarship provides virtually total financing, but only a limited number of students receive them. As previously noted only 12% of the medical students received these funds in 1975-76 although they comprised 36% of available aid monies. Thus the actual distribution of available financial aid funds is not realistically aligned with the need for such funds.

D. Unrealistically low borrowing limits set for medical students in present loan programs.

Rising costs (especially tuition), heavy borrowing during the undergraduate years, and lack of access to personal or family financial resources are all factors which cause many students to require higher annual loans or higher total debt ceilings than are permitted under the present Guaranteed Student Loan Program. This problem is especially acute for students from low income families since they do not have family resources to rely upon in emergencies.

4. Increasing debt burdens will create increasingly serious repayment problems for physicians during the postgraduate years.

The combination of increased levels of debt and interest rates that are close to or equal to commercial market rates will become a burden, particularly during residency when physicians' salaries are relatively low.

5. The proposed federally Guaranteed Loan Program for Health Professions Students contained in the Health Professions Educational Assistance Act of 1976 (PL 94-484) does not appear to be a viable program to meet medical student loan needs.

The proposed federally Guaranteed Loan Program for Health Professions Students differs from the existing Guaranteed Student Loan Program in the following significant ways:

1. This is a new program specifically for students in the health professions including medical students.

2. The maximum allowable loan is $10,000 per year with a total allowable debt of $50,000, but the loan may be used only to pay for educational expenses such as tuition and books.

3. Only 50% of the students in each medical school class are eligible to borrow from this program.

4. A medical school must be eligible to receive federal capitation in order for any of its students to participate in the loan program.

5. The interest rate is to be at commercial market levels (estimated to be between 10-12%) and must be paid annually. This means that a student who borrows $10,000 for four years will be required to pay $4,000 in interest alone during his/her final year of study.

Four of these provisions deserve special mention. The restriction that no more than one-half of any medical school class may borrow under this program is apparently designed to ensure that a sufficient number of students will participate in the National Health Service Corps Scholarship Program. The provision that the loans may be used only for educational expenses (specified as tuition, fees, books, and laboratory expenses) limits their value. Room, board, and other costs of personal maintenance may require additional borrowing, particularly for economically disadvantaged students. Third, current capitation requirements include willingness to accept assignment by the Secretary, DHEW, of a number of U.S. citizens from foreign medical schools as transfer students. Unless this requirement is amended, many medical schools may elect not to be eligible for capitation, thus eliminating the opportunity for their students to borrow under the program. Finally, the financial elements of the program were proposed and written into the legislation without consultation with the private banking community. Because it is often difficult to convince people that banks are not willing lenders in such programs, information specifically solicited by the Task Force about the reaction of major lending institutions toward this program and toward the Guaranteed Student Loan Program is presented in Appendix A.

Closing Statement

The enactment of the Health Professions Educational Assistance Act of 1976 (PL 94-484) marked significant changes from the federal policies of the previous decade with respect to medical student financing. These changes reflect a widely held view that because of the high potential earnings of physicians, the public should not subsidize the expenses of medical students. Such a view ascribes the principle benefits of medical education to the individual rather than to society.

The new legislation also took steps to increase the delivery of health care in areas with current shortages of health manpower by providing an expanded program of scholarships which obligate recipient students to practice for up to four years in such areas. The philosophical basis of this program is in sharp contrast to previous financial aid programs which were designed to encourage students from a wide spectrum of socio-economic backgrounds to pursue careers in medicine by providing grants and loans awarded on the basis of financial need.

The long term impact of current financial aid policies on the behavior and attitudes of future physicians, while difficult to guage, may well be adverse. A student confronted with the problem of paying off a large, interest-accumulating debt could opt for a minimum period of postgraduate training and seek a practice location where a lack of certifiable clinical competencies would not hinder hospital staff appointment. While this might alleviate physician distribution problems, it could also result in a lower quality of medical care. Alternatively, a student in similar circumstances could seek training in one of the more lucrative specialty fields simply because of higher anticipated income. In both instances, it is reasonable to predict that neither physician would be particularly sensitive to the need for controlling health care costs.

During the past several years, the expense of attending medical school has rapidly increased in response to inflationary pressures in general and to very significant increases in the tuition charged medical students in particular. There is reason to believe that tuitions at U.S. medical schools will continue to increase more rapidly than inflation. Direct federal assistance to medical schools through capitation grants has traced an uneven course over the past few years, but as a percentage of costs of educating a student, the capitation grants have continued to decline. Many federal policy planners have openly stated that capitation is an unwarranted form of subsidy which should be eliminated and that the revenue lost to the schools should be compensated through increased tuition. A dramatic example of this principle in practice was the increase in tuition at Georgetown and George Washington Universities in Washington, DC, following the termination of subsidies by the U.S. government. Tuitions at those two schools are now projected to be $12,500 and $9,000 per year, respectively, for first year students. Such tuition levels seem likely to discourage economically disadvantaged students from pursuing medical education, and -- even if loan funds commensurate with this magnitude of expense were available -- the resulting debt burdens would be substantial.

There is no doubt that physicians in the U.S. have the capability to repay

substantial educational debts. There is general consensus within the Task Force that the earning capacity of physicians argues strongly in favor of assistance being made available through loans rather than grants, with the exception of grant support for financially disadvantaged students in their early years of medical school study.

The Task Force is less clear on what limits, if any, should be established for student borrowing. There is little agreement among economists or bankers about what constitutes a reasonable educational debt and what relationship the level of debt should bear to the individual's earnings. Members of the banking community have stated unequivocally that a debt of $50,000 for educational expenses is excessive; a benchmark generally accepted by economists has been that debt repayment should be limited to 6% of gross income. Some constraint on the growth of the debts borne by medical students seems warranted. The Task Force believes that selective federal subsidies of financial assistance for medical students by the government are reasonable and in the best public interest.

The guaranteed loan program proposed by the Task Force represents what appears to be an appropriate balance among the needs of students for financial assistance, their participation in sharing the financial aid costs through repayment of the loans plus interest, the willingness of lending institutions to provide funds, and federal participation at a relatively modest level through acting as a guarantor and subsidizing interest for financially needy students.

Footnotes

[1] Survey of How Medical Students Finance Their Education 1974-75, U.S. Department of Health, Education, and Welfare, Public Health Service. NTIS publication No. PB 250-429/AS, December 1975, $6. (National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161).

[2] Koleda, Michael and Craig, John "A New Era in Medical Student Finance 1976-1980", Looking Ahead, September 1976, Vol. 2, No. 4, (National Planning Association, 1606 New Hampshire Avenue, Washington, D.C. 20009). Also, preliminary drafts of this study made available by its authors to the Task Force.

[3] The Role of Aid to Medical, Osteopathic and Dental Students in a New Health Manpower Education Policy, Congressional Budget Office, August 1976, $1.10, stock No. 052-070-03541-2, U.S. Government Printing Office, Washington, D.C.

[4] There are two ways in which SLMA achieves its purpose. The first is to buy the actual loan note from the borrower and then become responsible for collecting the interest payments and loan principle repayment itself. Secondly, SLMA may accept the loan note as collateral and make the principal value of the note available to the lender, in which case the lender assumes responsibility for collecting the interest payments which are then forwarded to SLMA. Be-

cause SLMA borrows with the full faith and credit of the federal government, it is able to obtain loans with interest rates that are substantially lower than the interest charged by a lender who is not assured of repayment by the federal government. The difference between the favorable interest rates at which SLMA obtains its funds and the prevailing rates in the guaranteed loan program provide the funds SLMA needs for its operating expenses and profit.

Appendix A: Reactions of Commercial Lenders to Guaranteed Student Loan Programs

When the broad outlines of the new Federal Guaranteed Loan Program for Health Professions Students became known in the spring of 1976, the Task Force asked Dr. Cooper to write on its behalf to selected members of the private banking community to determine their interest in the loan program. A copy of this letter and the responses are attached.

It is surprising to learn how little communication had occurred between the proponents of the new Federal Guaranteed Loan Program for Health Professions Students and the private banking community. The presumption that medical students will be viewed as desirable loan customers by the banks is not widely held by the representatives of the banking community with whom the Task Force has met. It has been pointed out that student loans do not generate future business and that future physicians, like all student borrowers, are likely to seek their mortgages or loans for establishing practice from banks other than those which have provided funds for an educational loan.

The threat of bankruptcy by medical students is real and growing because the level of indebtedness of medical students is increasing. Although the loans are guaranteed, any interruption in the repayment of the loan by the borrower necessitates paperwork and resultant delays which are costly to the lending institution.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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

WASHINGTON: 202: 466-5178

July 27, 1976

Dear :

At the request of the AAMC Task Force on Student Financing which we have established, I am writing a selected number of financial institutions to determine their receptiveness to two guaranteed educational loan proposals which have emerged from Senate and House Committees. Both of these proposals will be considered by different joint Congressional conference committees in the near future. The one proposal established a new guaranteed student loan program for students in the health professions; the other proposal amends the present guaranteed student loan program.

The proposed guaranteed student loan program for the health professions is a part of Senate Bill 5546. This bill if enacted would guarantee loans made to students by financial institutions in yearly amounts up to $10,000 and up to $50,000 totally. The interest rate would be determined annually by the Secretary of Health, Education, and Welfare, but it could not exceed 10%. The interest would accrue and be paid by the student from the origination of the note. The repayment of principal would not begin until 9 to 12 months after the borrower completed residency. In most instances this means that repayment would not begin until 4 to 8 years after graduation. The period of repayment could not be less than 10 years or more than 15 years.

The House of Representatives Bill 14070 renews and amends the present guaranteed student loan program. The proposed amendments would permit any eligible graduate student to borrow up to $5,000 annually with a maximum of $15,000 available for graduate study. The interest subsidy would continue and eligibility would increase from an adjusted family income of $15,000 to $20,000. Of particular significance is that the maximum special allowance would be increased from 3 to 5% beyond the 7% annual interest charge. Further, the special allowance would be tied to the average bond equivalent rates of ninety-one-day Treasury bills auctioned during the last three month period.

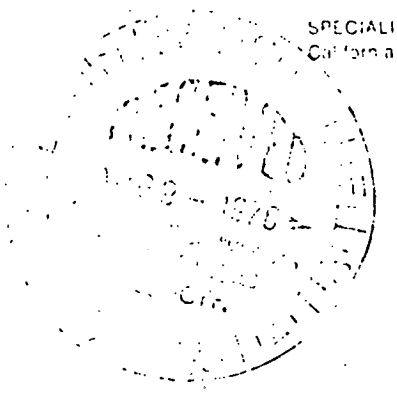
As our task force evaluated these two proposals, it desired to have information on the acceptability to financial institutions of a new guaranteed student loan program for health professions students which considerably increases permissible debt levels, lengthens repayment periods, and provides a rate of return which appears to be less than the proposed amended rate under the present GSL Program. We are most interested in your reaction to these two proposals and any recommendations you wish to make. We badly need more loan dollars for students studying in the health professions, but in order for a new guaranteed loan program for a special student group to be of value it must attract capital from private sector financial institutions.

We would appreciate an early response because of the anticipated imminent Congressional action. A member of our task force will contact you in the near future to answer any questions you may have. Your cooperation would be most helpful.

Sincerely,

John A.D. Cooper

BANK OF AMERICA



ROBERT H. BROWN
Vice President

August 6, 1976

Mr. John A. D. Cooper, M.D., PH.D.
President
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Suite 200, One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Cooper:

First, let me apologize for the delay in answering your letter. It seems to have found everyone out of town.

Secondly, I have not seen Senate Bill #5546 nor House Bill #14070 which precludes an opportunity for in-depth study and analysis, but will attempt to deal with the highlights.

Basically, we would oppose Senate Bill #5546 or any attempt to increase debt levels. The small number of participating financial institutions has created a burden on those in the program and increased debt limits will only further strain resources available for this type of financing.

Second, the interest rate will not even come close to covering the cost of long term funds not to mention acquisition and servicing costs. Financial institutions cannot be expected to continue to absorb substantial losses from these programs.

House Bill #14070 contains some minor adjustments in income, but falls short of being other than token. We would oppose increased debt limits for the reasons already stated.

Dr. Cooper, before we could endorse any student loan program, the revenue potential must be brought up to at least a "break-even" point. Further, it must be cited that the present program being administered by the office of Health, Education & Welfare has three key administration problems which add to the cost burden which this program places upon a lender.

The first results because of delays when claims are processed. The second, from the lack of a timely procedure for verifying that student participants are enrolled in school. The third stems from a lack of guidelines published

Mr. John A. D. Cooper, M.D., PH.D.
President

August 6, 1976

on a current basis. Administration procedures must be improved.

Trust this will assist your efforts.

Sincerely,

R. H. Brown
Vice President

RHB/mch
(213) 683-4115
ccs: K. V. Larkin, Senior Vice President
R. W. O'Brien, Jr., Senior Vice President

THE FIRST NATIONAL BANK OF CHICAGO

JOHN W. HUGHES III / VICE PRESIDENT
PERSONAL BANKING DEPARTMENT

August 9, 1976

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

Dear Dr. Cooper:

The First National Bank of Chicago in the last few years has curtailed its activities in Federally Insured Student Loans due primarily to:

1. Artificially low yields, i.e. maximum of 10%.

2. Uncertainty of the special allowance.

3. Default rate caused by students either not being prompt with their payments or declaring bankruptcy.

4. Lack of understanding over what constitutes proper collection procedures.

5. Inability to obtain payment on claims in a timely manner.

6. Lack of parental responsibility on the debt.

H.B. 14070 contains certain provisions that are certainly an improvement in the program and will curtail the abuses by student borrowers and lenders:

1. Loan limits for graduate and professional students raised from $10,000 to $15,000.

2. Change in the special allowance so that it floats with the 91 day treasury bill rate.

ONE FIRST NATIONAL PLAZA / CHICAGO, ILLINOIS 60670 / TEL. 312 732-4557

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

3. Student loan obligations cannot be discharged through bankruptcy.

This bill has certain weaknesses, however, and corrections have been suggested by various interested associations:

1. The special allowance should not have a floor and ceiling (of 1% and 5%), but be allowed to float freely with the 91 day treasury bill rate.

2. Some limit on the percentage of the total cost of education at a particular institution that is financible. This has been done for unregulated lenders, but does not apply to regulated lenders.

3. This bill does not address the inability of the Office of Education to promptly honor claims and other correspondence.

S.B. 5546 is certainly a positive step as it relates to the health professions, but I see no reason why the same lending rates, special allowance, and other provisions of H.B. 14070 should not apply. It appears that the only positive part of this bill centers around the total amount of allowed indebtedness and special repayment terms, but I take particular issue with the 10% interest rate cap.

I sincerely appreciate the opportunity to make known my views on these bills and would be happy to elaborate further if necessary.

With warm regards,

John W. Hughes III
Vice President

JWH:mmk

cc: William Ihlanfeldt

CONTINENTAL BANK

August 6, 1976

PAUL J. PFEILSTICKER
VICE PRESIDENT
312/828-8450

Association of American Medical Colleges
Suite 200
One DuPont Circle, N. W.
Washington, D. C. 20036

Attention: Dr. John A. D. Cooper

Dear Dr. Cooper:

Your letter arrived when Mr. Jim Matthews is on vacation. Because this is a highly important subject, I felt the reaponse should not await his return.

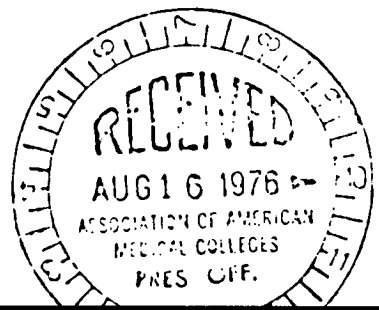
Well meaning as our Legislators might be I have a difficult time understanding the rationale behind Senate Bill 5546. I am of the view that you do little favor for students in any field to allow them to burden themselves with a total debt of the proportions suggested in that bill. Nor is it a great favor to the financial institutions to suggest such a protracted debt arrangement as up to 27 years. I also note from your letter that Senate Bill 5546 does not create any subsidy for the interest payment by the students. It has been our experience in the Illinois Guaranteed Loan Program, and in our AMA efforts, that about the maximum you can expect from a student is 7%, anything beyond that really does him no favor. They just cannot afford it. On the other hand, financial institutions cannot be attracted to 7% yielding investments. Currently, the Illinois Guaranteed Loan Program, because of subsidies, yields approximately 9%. The financial institutions in this area have a limited appetite for such a yield, and would be only slightly more interested at 10%. Obviously Senate Bill 5546 will not achieve its objective.

House Bill 14070 is substantially more attractive. It does not allow heavy over-burdening with debt. The yield could well be 12%. While budgeting is difficult on 91 day Treasury Bills the portfolio is not subjected to political cosmetic vagaries. It is clearly preferable to the Senate Bill.

I certainly hope that my comments will help you in your discussions with our Legislators. Should you have any further questions please contact me.

Yours truly,

PJP:SLP



SallieMae
Chartered by Act of Congress

STUDENT LOAN MARKETING ASSOCIATION
1055 Thomas Jefferson Street N.W.
Washington, D.C. 20007 202 333-8000

EDWARD A. FOX
President

August 11, 1976

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

Dear Dr. Cooper:

Thank you for your letter of July 27, 1976, in which you request our views on the provisions of Title III of HR 5546 (S 3239), which establishes a separate guaranteed loan program for health professions students, and HR 14070, which, among other things, amends the existing Guaranteed Student Loan Program. While their approach differs, both Bills are designed to increase the availability of loan funds for students in the health professions fields. We are pleased to provide you with our comments on these Bills. We have not, however, had the opportunity to discuss these comments with our Board of Directors. In addition, we have not undertaken any study of the policy considerations involved in the determination as to how to best meet the nation's critical needs for increased services in the health professions fields. We would hope that a record on the policy considerations would be developed through the legislative process.

We believe the guaranteed loan provisions of HR 14070 in general and, in particular, the provisions which establish a special allowance tied to the 91-day Treasury bill with a minimum payment of 1% and a maximum payment of 5%, will be of considerable help to the program. While other approaches might in part accomplish the same objective, the amendments contemplated by the Bill should provide the administrative and economic conditions needed to assure the continued availability of private capital to generally meet loan demands. The question as to whether the existing Guaranteed Student Loan Program, as so amended, would meet the further specific and specialized needs of health professions students for

loan funds is, however, more difficult to assess. The proposed increase in the aggregate debt ceiling for graduate students would pose no problem for us as a secondary market, but we are not certain how this increase will be viewed by the financial institutions that originate loans and whether they will respond to it with significant increases in credit.

The establishment of a new and separate health professions guaranteed loan program, as is provided for in HR 5546, would argue for the need for a distinct program to serve students in these disciplines. In the event this is the direction Congress takes, we would, of course, stand ready to assist the private sector in providing necessary loan capital as we have done with respect to the existing program. However, we question whether, as the bill now stands, the new program would be able to adequately attract private capital. For example, the House Committee on Education and Labor has proposed in HR 14070 a yield of up to 12% with the variable rate special allowance referred to earlier. If that judgement as to what is needed is reasonably accurate, and we are inclined to believe it is, the maximum 10% ceiling provided for in HR 5546, combined with the fact that the rate is fixed over the term of a loan, may not be adequate to encourage lenders to make such loans. This possibility becomes more likely in light of the longer loan maturities that also are provided for in the Bill. We might note, however, that the long-term fixed-rate feature, by itself, would not present a problem for us as a secondary holder since we are able to exercise some control in matching our investments in student loans with our borrowings. In any event, as might be suggested by our comments with respect to the increase in the individual debt ceiling proposed in HR 14070, we do not know to what extent an increase in individual loan ceiling such as proposed in HR 5546 can be expected to result in a corresponding increase in credit from the financial community.

Currently, a number of postsecondary institutions are acting as lenders under the GSLP. Their involvement as lenders under the program often reflects the uneven availability of credit to their students. Many times, students, including graduate professional students, are unable to obtain loans from commercial lenders in their home towns or elsewhere. Schools often function as lenders to bridge this gap and thereby assure their students of needed support.

Similar unevenness in the availability of credit could occur in a health professions loan program. The generally high quality of health professions schools, their relatively small numbers as compared with the total class of eligible institutions in the existing Guaranteed Student Loan Program, and the level of maturity and motivation of, and employment opportunities for, their students would perhaps argue for the reconsideration of the original terms of S 3239, now HR 5546, which permitted schools to participate as lenders.

I hope these observations are helpful to your Task Force in formulating a position with respect to the two Bills. If I may be of any further assistance, please feel free to contact me.

Very truly yours,

Edward A. Fox

Edward A. Fox
President

Appendix B: Task Force Bibliography

I. How Medical Students Finance Their Education

Koleda, Michael and John Craig, The Medical Student Aid Shortfall: Magnitude and Implications 1976-1980, National Planning Association, Washington, DC, June 18, 1976

Koleda, Michael and John Craig, New Realities in Medical Student Finance, 1976-80, National Planning Association, Washington, DC, July 1976

Weiler, William C., Loans for Medical Students: The Issue of Manageability", Journal of Medical Education, Vol. 51, June 1976, pp. 447-453.

_____, Overview of AAMC Studies of Medical Student Financing Supported in Part by Bureau of Health Manpower (BHM), November 9, 1976.

Mantovani, Richard and Travis Gordon, Research Design for Medical Student Indebtedness and Career Plans, 1974-75, AAMC Division of Student Studies, Draft dated March 26, 1976.

_____, Studies of Medical Student Financing - Medical Student Finances and Institutional Characteristics 1974-75, Final Report, AAMC, February 1977.

_____, Studies of Medical Student Financing - Medical Student Finances and Personal Characteristics, 1974-75, Final Report, AAMC, January 1977,

Lambdin, Julie, Survey of How Medical Students Finance Their Education, AAMC, December 1975.

_____, Medical Student Indebtedness and Career Plans, 1974-75, U.S. Department of HEW in cooperation with AAMC, September 1976.

_____, Survey of How Medical Students Finance Their Education, 1974-75, U.S. Department of HEW in cooperation with AAMC, December 1975

_____, The Role of Aid to Medical, Osteopathic, and Dental Students in a New Health Manpower Education Policy, Congressional Budget Office, August 10, 1976.

II. Sources of Financial Aid

A. Private

_____, American Medical Association Education and Research Foundation Loan Guarantee Program, Statistical Report, December 31, 1975.

_____, American Medical Association Education and Research Foundation Student Opportunity Loan Program, Report of Operations, March 31, 1976

_____, Workshop for Financial Aid Program Administrators, Summary of Banker's Panel Presentation, AAMC, Chicago, Illinois, January 31, 1977.

_____, "Study Finds GSL Lenders Limit Loan Access", Student Aid News, November 2, 1976, pp. 7-8.

_____, Loan Programs 1976-77, Graduate School of Business, Stanford University.

_____, United Student Aid Funds, Inc., Guaranteed Student Loan Program, December 3, 1976

_____, Report of American Bankers Association Student Loan Task Force, March 1975.

Correspondence with private lenders, July 1976.

B. Public

Dresch, Stephen, Federal Loan Programs for Graduate and Professional Students: Discussion and Evaluation, December 1, 1976.

Johnston, D. Bruce, Federally-Sponsored Student Loans: An Overview of Issues and Policy Alternatives, October, 1975.

_____, Fact Sheet for portions of "The Health Professions Educational Assistance Act of 1976" P.L. 94-484, enacted October 12, 1976, December 1976.

_____, Portions of the Bureau of Health Manpower Fact Sheet about the Health Professions Educational Assistance Act of 1976, P.L. 94-484.

Correspondence from Mary Jane Calais, Staff Director Student Financial Assistance Study Group, Department of Health, Education and Welfare, February 1, 1977.

III. Mechanisms of Financial Aid

A. Sallie Mae

Dresch, Stephen, Income Continget Loans for Higher, Graduate and Professional Education: A Further Exploration of the Issue of Ex Post Moral Hazard, September 30, 1976.

_____, Student Loan Marketing Association Annual Report, 1975.

B. Proposals

Challoner, David, M.D., "The Medical Student Pays for His Education: Income Contingent Loans", The New England Journal of Medicine, January 17, 1974, pp. 160-162.

Dresch, Stephen, Outline for a Proposed Federal Program of Loan Assistance To Graduate and Professional School Students, March 23, 1976.

_____, Income Protection Student Loan Program, 1976-77, Northwestern University

Nelson, Bernard, Gilbert Rodgers, Richard Bird, An Educational Opportunity Bank for Medical Education.

Reinhardt, U.E., On the Financing Medical Education, Princeton University.

_____, Health Professions Student Loan Program: View From the Campus, Position Paper presented by Participating Financial Aid Administrators of Health Professions Colleges and Universities in Region IV, April 1976.

_____, A Deferred Cost of Education Plan for Podiatric Medicine, American Association of Colleges of Podiatric Medicine, April 1976.

IV. Financing Minority Medical Education

Abarbanel, Karin, "Is a Relapse Ahead for Minortiy Medical Education?", Foundation News, November/December 1976, pp. 11-28.

Koleda, Michael and John Craig, A National Foundation Program of Student Assistance to Minorities, Women, and Rural Students in Medicine, Osteopathy, and Dentistry: 1976-1980, September 25, 1976.

_____, A Synopsis of a Proposal to Evaluate the Financial Factors Affecting U.S.Medical Schools' Efforts to Achieve Equal Representation of Minority Students, Expand Associates, Inc., July 1976.

V. Miscellaneous

_____, New Patterns for College Lending (to be sent to Task Force members)

_____, Credit for College Lending (to be sent to Task Force members)

_____, Student Loan Study, State of Wisconsin Higher Educational Aids Board Report #76-12, November 1975.

_____, Committee on Tuition Policy, Stanford University School of Medicine, July 1976.

aamc association of american medical colleges

August 29, 1977

Executive Council
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

The Task Force on Minority Student Opportunities in Medicine is pleased to submit the following Interim Report of its findings and initial recommendations to the Executive Council.

In the late 1960's society recognized the need to increase the number of ethnic minorities in the study and practice of medicine. Consonant with the acceptance and implementation of this initiative, early efforts to increase the enrollment of Black Americans, American Indians, Mexican Americans, and Mainland Puerto Ricans were successful. A variety of educational and financial programs were developed to support the recruitment and retention of minority students. At that time, the societal, political and economic climate supported the development of these programs; although in total, maximum response and cooperation of academic medical centers was not achieved.

By 1976 the political and economic climate had changed. In addition to the development of a national climate of general conservatism and an economic recession, the spectre of litigation based on "reverse discrimination" further blunted the initiative and reduced funding sources. We think it also correct to say that the issue of litigation serves to decrease the enthusiasm and interest of some schools in the development and continuation of minority programs.

This report discusses those issues that the Task Force considers critical for the continued development of opportunities for minorities in medicine.

Sincerely,

The Task Force on Minority Student Opportunities in Medicine

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Association of American Medical Colleges

Task Force on Minority Student Opportunities in Medicine
Interim Report - September 1977

Table of Contents

INTERIM REPORT

INTRODUCTION

The Association of American Medical Colleges Task Force on Minority Student Opportunities in Medicine was established by the Executive Council in February 1976, and was given the following charges:

1. To analyze problems faced by the medical schools in seeking to increase the enrollment of minority students;

2. To assess the problems faced by minority applicants in seeking access to medical education;

3. To evaluate the perceptions of minority students regarding the desirability of a medical career as opposed to alternative careers available to them;

4. To determine how both schools and students have dealt with educational challenges peculiar to students from disadvantaged backgrounds.

In addition, the Task Force was asked to review the structure and extent of special programs designed by medical schools to recruit, admit, retain, and graduate minority students* and to identify critical elements of successful programs. Finally, the goals established by the 1970 AAMC Minority Task Force were to be reviewed and an attempt made to determine why those goals were not attained. The Task Force was given two years to report its findings.

The AAMC Task Force on Minority Student Opportunities in Medicine, chaired by Dr. George Lythcott, Associate Vice Chancellor for Health Sciences, University of Wisconsin, Madison, has met four times. In keeping with its goals and objectives, the Task Force has invited presentations from experts in various fields to hear their views, findings, and concerns about minorities in medical education and practice.

The Task Force has received input and recommendations from a number of private organizations, minority organizations, premedical advisors, and minority medical students (see Appendix A). The Interim Report presents the findings on the basis of its efforts thus far and recommendations consistent with these, as well as priorities for issues the Task Force believes merit further study.

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*Definition of minority student includes: American Indian, Black American, Mexican American, and Mainland Puerto Rican.

BACKGROUND

Efforts to increase minority enrollment in medical schools intensified during the 1960's as a part of society's recognition of the need to correct past discrimination and inequities. At its 1969 Annual Meeting, AAMC adopted the position that "medical schools must admit increased numbers of students from geographic areas, economic backgrounds, and ethnic groups that are now inadequately represented." Financial support was obtained by medical schools to expand their recruitment of minority students. A Task Force was organized by AAMC in 1970 to investigate the underrepresentation of racial minority groups in medical education. One of the recommendations of the 1970 AAMC Task Force was to increase the representation of minorities in the M.D. degree programs from 2.8% in 1970-71 to 12% in 1975-76. This 12% goal was based upon a projection in which Blacks were used as a proxy for all minority groups. A more realistic goal for all underrepresented minority groups would have been 18%.

A review of the statistics shows that first-year minority student enrollment increased from 808 (7%) in 1970 to a peak of 1,473 (10%) in 1974. Following the peak in 1974, first-year minority enrollment decreased to 1,391 (9.1%) in 1975-76, then increased in absolute numbers to 1,400, but declined in percentage (9.0%) in 1976-77. Although the size of the Black applicant pool increased at a faster rate than was projected from 1970-71 to 1974-75, the number of Black students enrolled has been consistently lower than what had been projected by the 1970 Task Force (see Table 1 - page 3). In comparing the American Indian, Mexican American, and Mainland Puerto Rican applicants, Table 2 shows that the American Indian and Mainland Puerto Rican applicant pool decreased from 1973-74 to 1975-76 while the Mexican American applicant pool increased.

Several factors have played a part in the failure to achieve the 12% first-year enrollment goal by 1975-76. Several assumptions made by the 1970 Task Force never came to fruition. First, the Task Force projected a 107% increase in the size of the Black applicant pool. The rate of growth of the applicant pool increased steadily until 1972-73; after which it began to decline. Consequently, the 107% increase was not achieved. Secondly, the acceptance rate of all minority applicants peaked at 57% in 1971-72, thereby never attaining the 75% acceptance rate projected by the Task Force. As a result, the number of students enrolled increased by only 49% in comparison to the projected 107%. Although several of the 1970 Task Force's assumptions may have been unrealistic, the current Task Force cannot escape the conclusion that the total effort by all medical schools to recruit, admit, and graduate minority students has not been totally satisfactory.

PROGRESS

The Task Force recognizes that there are numerous issues associated with the efforts to increase opportunities for minorities to enter medical education in greater numbers and to graduate them as practicing physicians in order to alleviate some of the health care problems of the country. Some aspects of the problems confronting minorities in medical education require additional research by the Task Force and specific recommendations to address these issues will be discussed in the Final Report.

Table 1

Comparison of "Projected" and "Actual"
Applicant Pool and Matriculant Statistics
for Blacks from 1970-71 to 1975-76

	Applicants		Matriculants		
Year	Projected*	Actual	Projected	Actual+	% Black Applicants Accepted
1970-71	1218	1250	914	697	56
1971-72	1229	1552	922	882	57
1972-73	1785	2382	1339	957	40
1973-74	2058	2227	1544	1027	46
1974-75	2310	2368	1733	1106	47
1975-76	2520	2286	1890	1036	45
Increase from 1970-71 to 1975-76	107%	83%	107%	49%	

* The projected figures are based on the probability of increasing the retention of minorities (at the undergraduate college level) interested in pursuing a medical career from 25% to 35%.

+ Actual matriculant figures include repeaters.

Source: Report of the Association of American Medical Colleges Task Force, April 1970 and Admission Action Summary Reports.

Note: In the Task Force report, Blacks were used as a proxy for all minority groups since information on American Indians, Mexican Americans, and Mainland Puerto Ricans was lacking.

Table 2

American Indian, Mexican American and Mainland Puerto Rican Applicants and Matriculants for the 1973-75 Academic Years

	American Indian	Mexican American	Mainland Puerto Rican
1973-74			
Applicants	240	349	233
Matriculants	44	174	56
% Applicants Accepted	18.3	49.9	24.0
1974-75			
Applicants	131	437	170
Matriculants	71	227	69
% Applicants Accepted	54.2	51.9	40.6
1975-76			
Applicants	128	434	204
Matriculants	60	224	71
% Applicants Accepted	46.9	51.6	34.8

The Task Force evaluated a stratified sample of twenty-two minority applicants (eleven accepted and eleven rejected) matched according to their score on the science MCAT subtest and overall Grade Point Average. Through the evaluation of these cases, experience with the Simulated Minority Admissions Exercises, and the review of additional information, several areas of concern were highlighted:

1. Receptivity and Commitment of Medical Schools
2. Recruitment
3. Counseling at Undergraduate Institutions
4. Admissions Assessment and the Application Process
5. Special Programs and Retention
6. Student Responsibility
7. Financial Aid

GENERAL RECOMMENDATIONS

I. Receptivity and Commitment of Medical Schools

Commitment is a moral, spiritual, and intellectual principle; a set of qualities and personal resources reflected totally, in part, or not at all from the top of the administrative hierarchy of the institution, particularly the dean and his immediate senior staff, and department heads. As a practical matter, however, the central focus in an individual medical school revolves around the position taken and the leadership provided by the dean, particularly the ability to have these commitments reflected by his staff and department chairmen. Commitment only becomes meaningful when it is translated into effective action. This action is manifested in the tone of the institutional environment, its various programs and support services, and the involvement of the faculty.

Commitment requires the involvement of the faculty in the development of a good program for minority students. It is recognized that the medical school faculty has become accustomed to students who are highly proficient in particular academic skills and primarily from a white middle class background but the faculty must become more sensitive and knowledgeable of students from various educational and ethnic backgrounds. It is important for the medical school faculty to understand that their responsibility does not end with the admission of minority students; in fact, it is just beginning. As Dr. Odegaard appropriately stated in Minorities in Medicine,

> "The intramural phase begins with the matriculation of minority medical students and their continued appearance within the walls of the medical center.

> At this stage, an increasing number of faculty begin to have direct contact with minority persons as medical students now directly involved in their environment. At this stage the general ethos of a larger part of the faculty and administration becomes critical in determining the kind of provisions that will be made by the school for minorities enrolled as students. It is also at this stage that the general ethos of the faculty at large becomes more apparent to minority students and influences more substantially the kind of reaction they will develop toward the school."[1]

Commitment also requires the provision of adequate role models in the teaching of basic and clinical science, and in the administration. Increasing the number of role models is dependent not only upon the support of the dean but more importantly upon the commitment and support of department chairmen, who in many cases are primarily responsible for faculty recruitment. Faculties with competent Black Americans, Mexican Americans, American Indians, and Puerto Ricans will facilitate the recruitment of minority students and will provide role models after whom aspirants can model themselves.

The issue of commitment, then, is the crux of the matter. Commitment in the context of this report, means not only increasing the numbers of minority medical students admitted and graduated, which is a means to an end, but also commitment to the long-term goals of providing quality medical services to communities across the nation, particularly to those who live in underserved areas--the inner cities, the barrios, the rural regions, and to those who represent other special population groups, whose needs for medical services present unique problems.

As a long-range goal to increase the number of minority physicians, the Task Force recommends that:

1. Medical schools develop retention programs covering a broad range of support resources, including the personal, social, and academic aspects of a minority student's life.

2. Medical schools should also support organizations among minority students that serve vital social functions, and enable minority students to contribute collectively to the cultural, political, and academic life of the medical

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[1] Odegaard, Charles E., Minorities in Medicine from Receptive Passivity to Positive Action 1966-76, New York: Josiah Macy, Jr. Foundation, 1977, p. 117.

school. The sense of identity developed through the sponsorship of activities, provides students with the opportunity to perceive the medical school environment as one that fosters confidence through collective as well as individual success.

3. An office with the responsibility for representing the interests of minority medical students should be established. The staff of this office should be sensitive to minority needs and have an understanding of minority values and culture. This office should be an integral part of the medical school administration.

4. Medical schools should expand their efforts to recruit and develop minority faculty members who can serve as role models for minority students.

5. Medical schools which do not have adequate numbers of minority faculty should attempt to provide preceptoral or other opportunities for their minority students to interface with minority health professionals outside of the school.

This issue will be studied in more detail by the Task Force and additional recommendations will be reflected in the Final Report. Part of the process in the evaluation of institutional commitment and supportive services programs will require the Task Force to visit selected medical schools. Arrangements for visits to medical schools by Task Force members and AAMC staff has been initiated. The schools were selected on the basis of geographic location, minority group population, public/private status, programs directed toward minority students, and track record with respect to minority student admission and retention. The visits are scheduled to take place before the end of this calendar year (see Letter to Deans, Appendix B).

II. Recruitment

The Task Force is concerned with the lack of substantial increases in the minority applicant pool over the past few years. The term "recruitment" has come to have the restricted meaning of increasing enrollees into medical school. This concept must be enlarged to mean increasing the numbers of well qualified applicants and enrollees.

A. The Applicant Pool - General

Increasing the supply of qualified minority applicants will require a process of early identification and tracking of intelligent and strongly motivated minority students. This identification process will depend upon the establishment of meaningful relationships between medical schools and undergraduate colleges. Accordingly, the Task Force recommends that:

1. Medical schools increase their efforts to improve communication with undergraduate advisors, faculty in beginning science courses, and minority program officers at undergraduate institutions.

2. Medical schools offer a variety of experiences (seminars, guidance and advising, special classes, evening research, etc.) to acquaint undergraduate minority students with the nature of medical education.

3. Medical schools should use their influence to stress the value and importance of good advising on the undergraduate campuses, since this important function has often been relegated to a minor activity at many undergraduate colleges and universities.

In addition, the Task Force expects to study the recommendation for the development of self-instructional units in general chemistry, college mathematics, college physics, and cellular-molecular biology for use by students with deficient educational backgrounds.

B. The Applicant Pool - Black Undergraduate Colleges

Students from predominantly Black undergraduate colleges represent a significant portion of the applicant pool. As seen in Table 3 (page 9), for the 1976-77 academic year, 33 percent of the Black applicants and 24 percent of the first-year Black matriculants were from predominantly Black undergraduate colleges.

The Task Force also discovered that the medical school acceptance rate for Black students from predominantly Black undergraduate colleges has been considerably lower than the acceptance rate for Black students from predominantly White colleges. This phenomenon will be elaborated upon and expanded to include the other underrepresented minority groups (American Indians, Mexican Americans, and Mainland Puerto Ricans) in the next phase of the report.

Table 3

Comparison of Black Applicants and Matriculants from Predominantly White and Predominantly Black Undergraduate Institutions for 1970-76

Type of Undergraduate College	Applicants #	Applicants %	Matriculants #	Matriculants %
1970+				
Predominantly White	DNA[1]		165	48
Predominantly Black	DNA		180	52
1971+				
Predominantly White	404	54	265	57
Predominantly Black	340	46	202	43
1972+				
Predominantly White	619	56	354	63
Predominantly Black	487	44	209	37
1973+				
Predominantly White	985	59	505	68
Predominantly Black	673	41	235	32
1974+				
Predominantly White	1097	60	524	66
Predominantly Black	726	40	274	34
1975*				
Predominantly White	1501	66	703	74
Predominantly Black	787	34	242	26
1976*				
Predominantly White	1689	67	735	76
Predominantly Black	836	33	231	24

+ AAMC-SNMA Cooperative Study

* AAMC Data Files

[1] Indicates data not available.

An item of priority for the Task Force will be the identification of those schools with sizable minority populations who have the potential to successfully increase the size of the minority applicant pool. Of particular merit would be the early development (i.e., at the freshman undergraduate level) of recruitment and retention programs in preprofessional studies. Such schools could serve as a proving ground for the implementation of recruitment and retention innovations especially if coupled with medical schools in regional associations. Such "consortia" could increase the acceptance of minority students beyond the 28% level (1976) and provide a base for the evaluation of the cost effectiveness of such joint recruitment and retention efforts.

III. Counseling at Undergraduate Institutions

A large number of minority students are unaware of when to apply, where to apply, and are frustrated by the complexities inherent in the process of filing an application. Applications are frequently incomplete, deadlines are often not met, and students sometimes fail to take required courses or to provide important data on the narrative section of the application. In addition, minority students' selection of medical schools to which to apply is done with inadequate information. Since some medical schools are more research-oriented, some are more competitive, and others provide more support programs, it is important for students to select schools compatible with their career goals and needs. Information provided by the Task Force's many invited discussants and its own analysis of applicant cases, clearly indicates that there is a lack of adequate counseling at the undergraduate level in regard to preparatory courses needed for medical school, the application process, and the selection of medical schools to which minority students should apply.

Preliminary information indicates that a substantial number of minority students tend to apply only to Howard and/or Meharry. Based on the belief that Howard and Meharry are more receptive to minority students, these applicants fail to apply to enough other schools and thus place themselves at a competitive disadvantage. The Task Force will analyze additional data to assess whether minority students apply to an appropriate selection and number of schools to maximize their chances of admission.

IV. Admissions Assessment and the Application Process

A. The Application Process: The New MCAT

Inasmuch as the New MCAT is too recent an innovation to assess its effect upon the minority student application, the Task Force was forced to indulge in some conjecture. With regard

to the New MCAT's effect, the view of the Task Force is that:

1. In its emphasis upon problem-solving and reading skills, the New MCAT may provide greater discrimination among students from differing socioeconomic and demographic backgrounds than did the former MCAT.

2. Sincere efforts have been made to eliminate cultural bias from the questions in the New MCAT.

3. Use of a fifteen interval scoring system as opposed to the 60 interval scoring of the old MCAT reduces the opportunity for misuse of the scores.

4. Separation of the former Science portion into biology, chemistry, and physics, will permit admissions committees as well as applicants and their advisors to assess specific areas of strength and weakness of candidates.

5. Less emphasis upon "speed" in the New MCAT will be an aid to students who wish to spend more time on individual questions.

The Task Force has reviewed a copy of the chapter, "How to Study for the New MCAT", which was omitted from the New MCAT Student Manual. This chapter provides relevant and valuable information to all students preparing for the New MCAT.

The Task Force addressed the use of the MCAT in the admissions process, and its impact on the selection of medical students. It recognizes that the old MCAT was designed only to predict success in the basic sciences but that the New MCAT is designed also to relate to performance in clinical situations. The state of the art is such that significant effort and experience will be required before appropriate data can be developed to support the latter application. The Task Force is also aware that it is possible for test scores as with other quantified measures to assume undue weight in admissions decisions. Further it noted the importance of evaluating non-cognitive characteristics in these situations and that this is not the purview of the New MCAT.

In recognition of these issues the Task Force recommends:

1. Admissions committees exert caution to restrict the use of New MCAT data to those applications for which supportive information is available. Further, it strongly supports the conduct of the necessary research and development projects both by the AAMC and its individual members to make possible the assessment of relevant non-cognitive characteristics as well as efforts to extend the value of the New MCAT as a predictive tool.

2. Publication by the AAMC of the chapter, "How to Study for the New MCAT", which was initially omitted from the New MCAT Student Manual.

B. The Application: Non-Cognitive Assessment & Student Interviewing

The development of the Simulated Minority Admissions Exercises (SMAE)[2] with its emphasis on non-cognitive assessment has been a positive force in the admission of minority group students to medicine and to other health education careers. Since the Simulated Minority Admissions Exercises was implemented in 1972, several schools and over 600 individuals have participated. Participants have included admissions officers, medical school faculty, deans, minority affairs officers, premedical advisors, etc. Anecdotal responses from the various participants indicate that the workshop has been valuable in the evaluation of minority applicants as well as for general training of admissions committee members.

The SMAE stresses non-cognitive assessment as a means to increase the predictability of acceptable performance in medical school. Medicine needs predictors of physician performance. This is a difficult task since such predictors must encompass the non-cognitive domain.

As demonstrated by the research of Sedlacek and others [3], admissions committees can enhance their successful prediction of minority student performance by the assessment of certain non-cognitive information: self concept, reaction to racism, self appraisal, long-range goals, support person or persons, leadership experiences, community interest, and medical interest. The Task Force believes that the interview process is extremely important to elicit this type of information from students in order to put the cognitive data in proper perspective. In the SMAE monograph, Dr. Paul Elliott states:

> "In many respects, the application forms for medical school and the information transmitted therein as well as the assessment of biographical data and of letters of recommendation (all normal sources of non-cognitive data) are established within the framework of the traditional applicant. As such, they often are of limited value in the assessment of minority applicants ....Often, the only point at which non-cognitive data can be accurately determined for students from the non-majority cultures is during the interview."[4]

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[2] AAMC, Stimulated Minority Admissions Exercises: Participant's Workbook, Washington, D.C., 1974.

[3] Sedlacek, William and Brooks, Glenwood C., Jr., Racism in American Education: A Model for Change, Chicago, Il., 1976.

[4] D'Costa, Ayres G. and Prieto, Dario O., editors, "SMAE: An Approach to the Appraisal of Non-traditional Applicants to Medical School," unpublished Monograph.

Accordingly, the Task Force recommends that:

1. The SMAE be updated and broadened in its scope to include other minority groups in addition to Black Americans and Mexican Americans.

2. The AAMC increase its effort to develop instruments and/or procedures for the use of non-cognitive information in the admission of medical students and in the prediction of physician performance.

3. The AAMC continue to work with medical schools toward the improvement of the interview as a tool of admission via SMAE workshops, publications, and training programs.

The Task Force recognizes that AAMC is presently conducting a study of the admissions process. This study will include some evaluation of interview techniques. Data from this study should be of valuable assistance in future analysis of this area.

V. Special Programs and Retention

A. Summer Programs

The present array of summer programs provided by many of the medical schools is variable, both in target population and academic content. Target populations range from secondary school students to those at the undergraduate college level to new medical school matriculants. The academic content ranges from study skills to reading comprehension to specific science courses. Some medical school programs provide a preview of what the student can expect when the academic year begins, while in others the courses provided permit the student to gain academic credits, thereby reducing the course load during the academic year. Many students have reported that the summer programs were helpful to them, not only for the academic reinforcement they received, but also because the programs afforded them the opportunity to adjust to a new environment. Students also felt that because the programs are held for 6-10 weeks during the summer, they do not permit them the opportunity to work. As a result, it becomes critical for these programs to provide some type of financial assistance, possibly a stipend. A more detailed analysis and review of the summer programs will be provided in the Final Report

B. Support Programs After Matriculation

An organized academic reinforcement program for all students who are having academic difficulty is necessary. Some students regardless of ethnic background, may have been poorly prepared in certain areas and with some assistance, would successfully complete medical school. Such programs have been implemented in some medical schools, but in many institutions no organized form of academic assistance is available. Developing a model retention program for minority students will receive the attention of the Task Force over the next few months.

VI. Student Responsibility

The Task Force takes the very strong position that the student has a clear responsibility in the whole matter of minority medical student education. While we strongly support the minority student's right to certain expectations from the academic medical center and its affiliates, it is also expected that the student will make the most of this opportunity to get a quality medical education. The minority student should strive for excellence, should not be manipulative in the pejorative sense, and should offer every assistance to positively influence the program of which he/she is a part, feeling free to enter into dialogue with faculty and administrators alike in rationally approaching program and educational goals.

Further, while the Task Force recognizes that self-awareness, self-pride, and ethnic pride are fundamental to the development of a secure and successful adulthood, it views with some concern the fact that these personal goals of the minority students have often led to a self-imposed isolation and a withdrawal from valuable interaction with non-minority peers and faculty. Since a physician must be committed to healing the sick whoever they may be and interacting with families in need of medical care, the Task Force feels strongly that minority medical students must begin to interact with others during this period of training and that the cross-fertilization of ideas, concerns, directions, and dreams can do nothing but enhance their final functioning as a physician. We would like to see this process of exchange of ideas, be they antagonistic or supportive, viewed as valuable and necessary for the complete and individual development of all budding physicians, Black or White, male or female, rather than as a process during which one loses self-identity. It is the Task Force's belief that young minority adults in 1977 have gained sufficient personal strengths to allow that this can, in fact, occur. Moreover, the gap which has existed between the all-White medical school and the minority medical student, which the latter abhors, will not be bridged completely unless the minority student also is willing to take some of the responsibility in building the foundation for the bridge.

VII. Financial Aid

The Task Force recognizes that the rising costs of medical education coinciding with insufficient student financial aid resources will cause serious problems for minority students. It was agreed within the Task Force that since the AAMC had already established a Task Force on Student Financing, that financial assistance would not be a priority for the Task Force on Minority Student Opportunities in Medicine. Instead, to insure appropriate input a subcommittee of the Task Force was assigned to act as liaison with the Task Force on Student Financing.

The Task Force on Minority Student Opportunities in Medicine wholeheartedly endorses the interim recommendations of the Task Force on Student Financing. The recommendations are:

A. Short Term

1. The Health Professions Student Loan Program should be funded at the levels authorized in PL 94-484 of $26, 27, 28 million for Fiscal Years 1978, 79, and 80.

2. The limits on the amounts that may be loaned to medical students under the existing Guaranteed Student Loan Progrmm should be immediately increased for Fiscal 1978 from $5,000 annually to $10,000. The lifetime maximum should be increased to $20,000.

3. The funding for the new Scholarships for First Year Students of Exceptional Financial Need should be increased, and the program should be expanded to include second-year students of exceptional financial need.

4. Medical schools should be encouraged to work with the American Medical Association Education & Research Foundation (AMA-ERF) to expand the capability of local banks to make AMA-ERF guaranteed loans.

5. Because of increasing dependence upon private capital markets as sources of financial support for medical students, medical schools should develop better relationships with lending agencies in order to help their students secure access to loan funds.

6. Counseling of medical students and prospective medical students about the realities of student financing and expected future incomes should be improved.

B. Long Term

1. The AAMC should endorse the establishment of a new Guaranteed Student Loan Program for medical students.

2. The Task Force does NOT recommend the development of a loan program with repayment contingent upon income.

The Task Force strongly believes that with the increasing changes in financial aid resources, payback mechanisms, etc., it is essential that medical schools assist students in the future planning of their personal finances as well as provide financial aid counseling. It is also incumbent upon the student to recognize that his/her participation in the establishment of a realistic budget, and the development of a financial aid package is primarily his/her own responsibility.

Appendix A

Presentations were made by the following organizations and individuals:

1. Rand Corporation

   Al Williams, Ph.D.
   John Rolph, Ph.D.

   Presented a study on minorities in the admissions process.

2. National Association of Medical Minority Educators, Inc.

   Rudolph M. Williams, President

3. Minorities in Medicine

   Charles Odegaard, Ph.D.

4. GSA Committee on the Medical Education of Minority Group Students

   Walter Leavell, M.D.

5. Pre-medical Advisors

   Dr. Charles Chantell
   Chairman of Department of Biology
   Chief Professional Advisor
   University of Dayton, Ohio
   Past chairman of the Central Associaton of Advisors for the Health Professions

   Dr. Prince Rivers
   Acting Executive Secretary
   Minority Access for Research
   Careers-NIH
   Past Allied Health Advisor and Chairman of the Pre-medical Committee at Fisk University

   Dr. Raymond Barreras
   Chairperson-Science/Math/Advisor
   Navajo Community College
   Past Advisor to Pre-meds at Tuskegee Institute

6. Minority Students*

Ms. Cynthia Henderson, second year, University of Illinois
Mr. Terry Mason, second year, University of Illinois
Ms. Linda Murray, third year, University of Illinois
Mr. Steven Keith, fourth year, University of Illinois
Ms. Vilma Colon, first year, University of Illinois
Ms. Maria Munoz, first year, University of Illinois
Mr. Carlos Flores, third year, Northwestern
Ms. Lois Steele, third year, University of Minnesota-Minneapolis

*Students from other geographic areas will be interviewed during the forthcoming months. In addition, interaction with resource persons as appropriate will continue.

Appendix B

association of american medical colleges

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

June 8, 1977

202: 466-5175

Dear :

As you are aware, the Association of American Medical Colleges established the Task Force on Minority Student Opportunities in Medicine in October of 1976. The goals and objectives of the Task Force are as follows:

1. To analyze problems faced by the medical schools in seeking to increase the enrollment of minority students;

2. To assess the problems faced by minority applicants in seeking access to medical education;

3. To evaluate the perceptions of minority students of the desirability of a medical career as opposed to alternative careers available to them;

4. To determine how both schools and students have dealt with educational challenges peculiar to students from disadvantaged backgrounds.

In order for the Task Force to fulfill these stated objectives, it feels that it is essential to visit several medical institutions to gain additional information through interaction and discussions with medical school faculty, administrators, Deans of Student Affairs, Admissions Directors, and students. A representative sample of medical schools was selected on the basis of ownership, geographic location, minority group population, and programs directed toward minority and disadvantaged students. It is suggested that the site visit be conducted by two members of the Task Force and one AAMC member, and take place over a period of one and one-half to two days.

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Page 2
June 8, 1977

Your school has been recommended by the Task Force as one of the institutions it would like to visit and I would like to request your cooperation for this site visit and ask you to encourage your staff to meet with selected Task Force members at a convenient time. If you agree, an AAMC staff member will contact you or your designate to work out the necessary arrangements for a visit to your school. We anticipate that the visit will take place before the end of this calendar year. I want to thank you in advance for your cooperation and invite you to call me if you have any questions.

Sincerely,

John A. D. Cooper, M.D.

Appendix C

Bibliography

1. Beattie, G.E. et al (Chairperson). Access to the Medical Profession in Colorado by Minorities and Women. Colorado: Colorado Advisory Committee to the U.S. Commission on Civil Rights, 1976.

2. Cooper, W.D., Lee, C., and Williams, A.P. Factors Affecting Medical School Admission Decisions for Minority and Non-Minority Applicants: A Comparative Study of Ten Schools. Draft.

3. Medical Students. Journal of the American Medical Association Index Issue: Medical Education in the United States, 1974-75, 234:1336-1339, December, 1975.

4. Dube, W.F. Medical Student Enrollment, 1969-70 through 1973-74. Journal of Medical Education, 49:302-307, 1974.

5. Johnson, D.G.,Smith, V.C., and Tarnoff, S.L. Recruitment and Progress of Minority Medical School Entrants, 1970-72. Journal of Medical Education, 50:713-755, Supplement, July, 1975.

6. Gordon, T.L, and Dube, W.F. Medical Student Enrollment, 1971-72 through 1975-76. Journal of Medical Education, 51:144-146, 1976.

7. Dube, W.F. and Johnson, D.G. Study of U.S. Medical School Applicants, 1974-75. Journal of Medical Education, 51: 877-896, 1976.

8. May, J.T., Rudor, M.H., and Kerr., J.L. Longitudinal Study of Health Careers from Project Talent. Washington, D.C.: Office of Health Resources Opportunities, 1976.

9. Thieme, F. (Chairman). Minority Group Participation in Graduate Education. National Board on Graduate Education. Washington, D.C.: National Academy of Sciences, 1976.

10. Odegaard, C.E. Minorities in Medicine from Receptive Passivity to Positive Action, 1966-76. New York: Josiah Macy, Jr. Foundation, 1977.

11. Sedlacek, W.E. and Brooks, G.C., Jr. Racism in American Education: A Model for Change. Chicago, Illinois: Nelson-Hall, 1976.

12. Nelson, B.W. (Chairman). Report of the Association of American Medical Colleges Task Force to the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students. Washington, D.C.: Association of American Medical Colleges, 1970.

13. Lefkowitz, B. The Role of Aid to Medical, Osteopathic, and Dental Students in a New Health Manpower Education Policy. Stock Number 052-070-03541-2. Washington, D.C.: Government Printing Office, 1976.

14. D'Costa, A.G. et al. Simulated Minority Admissions Exercises: Participant's Workbook. Washington, D.C.: Association of American Medical Colleges, 1974.

15. Smith, V.C. The Study of Recruitment and Progress of Minority Group Medical Students. Presented at the 84th Association of American Medical Colleges Annual Meeting. Washington, D.C.: Student National Medical Association, November 6, 1973, Pp. 22-26.

16. Lambdin, J.A. Survey of How Medical Students Finance Their Education, 1974-75. DHEW Publication No. (HRA) 76-94. Washington, D.C.: Health Resources Administration, 1975.

17. Manly, H.F. 33 Programs to Increase Educational Opportunity for Minorities in the Health Professions. Washington, D.C.: Association of American Medical Colleges, 1971.

18. Holmstrom, E.I., Knepper, P.R., and Kent, L. Women and Minorities in Health Fields: A Trend Analysis of College Freshmen. Volume III, A Comparison of Minority Aspirants to Health Careers. Policy Analysis Service. Washington, D.C.: American Council on Education, 1977.

TASK FORCE ON GRADUATE MEDICAL EDUCATION

The appointment of a Task Force on Graduate Medical Education was authorized by the AAMC Executive Council on January 14, 1977. The scope of the Task Force's responsibilities was laid out in a paper which was distributed to each member of the Council of Deans in advance of the 1977 Spring Meeting in Scottsdale, Arizona.

The task force held its first meeting on June 13-14, 1977. The minutes of that meeting (less appendices B & C) follow. Note that Appendix A is a list of the Task Force membership. A second meeting of the Task Force will be held October 31-November 1, 1977.

SUMMARY NOTES OF MEETING
TASK FORCE
ON
GRADUATE MEDICAL EDUCATION*

June 13-14, 1977

Washington, D.C.

PRESENT: Task Force Members

Jack D. Myers (Chairman)
Gordon W. Douglas
Harriet P. Dustan
Sandra Foote
Cheryl M. Gutmann
William P. Homan
Donald N. Medearis, Jr.
Richard C. Reynolds

Staff Consultant

John S. Graettinger

Observer/Participants

John Mather
William D. Mayer

Staff

James B. Erdmann
James I. Hudson
Hilliard Jason
Davis G. Johnson
H. Paul Jolly
Thomas J. Kennedy
Joseph A. Keyes
Richard M. Knapp
Mary H. Littlemeyer
Alan C. Mauney
Thomas A. Morgan
A. Diane Newman
Mignon M. Sample
John F. Sherman
August G. Swanson

ABSENT: Task Force Members

Steven C. Beering
D. Kay Clawson
Samuel B. Guze
Robert M. Heyssel
Wolfgang K. Joklik
Stanley R. Nelson
Duncan Neuhauser
Mitchell W. Spellman

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*A revised list of the task force is appended to these notes (Appendix A).

ABSTRACT

The AAMC Task Force on Graduate Medical Education held its first meeting at the AAMC Headquarters, Washington, D.C., on the afternoon of 13 June 1977, and the morning of 14 June 1977. Items #1 through #6 in the agenda for that meeting were covered in the first session. On the second day, the task force reviewed issues that had been summarized in the synopsis previously distributed to the task force as "The Clear and Evident Problems." These were (1) availability of positions for domestic graduates, (2) the demise of the foreign medical graduate, (3) graduate physician--student or employee?, (4) the role of the graduate medical faculty, (5) governance and control, (6) accreditation, (7) specialty distribution, and (8) financing.

To these the task force contributed the following additional problem areas:

1. Multiple functions of residents as (a) learners, (b) teachers, and (c) physician practitioners;

2. Flexible schedule programs;

3. Learning technical skills in a "private" setting;

4. Maintenance and development of patient population for education--numbers, types, reimbursement policies, quality of care, quality of education;

5. Internship vs. residency year "1"
   (a) career counselling and decision
   (b) broad clinical experience before narrowing;

6. Static vs. peripetatic graduate medical education;

7. Articulation of U3 and 4 with G1 and 2;

8. Entrance requirements into graduate medical education;

9. FMG and program quality assessment; and

10. Criteria for program and institutional evaluation.

The task force identified two areas for early attention by working groups. They were (1) the quality of the graduate medical education process and (2) the system for the accreditation of graduate medical education. The task force considered of great importance the financing of graduate medical education and physician specialty distribution. However, there have been several recent studies and reports on these areas, and the task force will review the available information before deciding to launch working groups.

The task force suggested several strategies that might be explored:

1. Involve, as soon as possible, individuals from the certifying boards and RRCs to organize plans for deliberating with a working group or with the task force as a whole about the concepts of quality control.

2. Distribute special requirements of all 23-24 specialties to a working group. After their careful scrutiny, the group could develop a strategy for discussion with those who generate the special requirements.

3. Examine recommendations from earlier studies that have not been implemented with the view of developing more successful strategies, i.e., why have some been implemented and others not?

4. Explore the possibility with ABMS of cosponsoring a 2-3 day conference to be held next fall or early winter. This would involve all the certifying boards and would afford an opportunity for an in-depth critique of each board's current certifying requirements. This could involve individuals who are in charge of the boards, such as the chairman and secretaries in the same discipline but perhaps from the professorial societies in the CAS or from the academy of the specialty.

The chairmen of the subgroups for Items #1 and #2 will be identified. Task force members will advise the Chairman of the particular subgroup which each might find of particular interest. Also, the task force will recommend individuals to serve as members of the subgroups.

The next meeting of the task is scheduled to be held October 31-November 1 in Washington, D.C.

Summary notes of the June 13-14 meeting follow.

OPENING REMARKS

Jack D. Myers, M.D., Chairman, commented that he looked upon this AAMC task force as a group with important work ahead of it. In the course of its deliberations, the task force will be calling on various consultants and helpers, particularly in its subgroups, who are external to the AAMC. Dr. Jack Graettinger has agreed to serve as a staff consultant to this effort. AAMC staff who will work closely with the task force are August G. Swanson, M.D., Mary H. Littlemeyer, and Alan C. Mauney.

Perhaps it is not too surprising that this field of graduate medical education is still unsettled in this country, because 50 years ago, graduate medical education did not amount to much in the United States. In fact, graduate medical education expanded to include most of this country's medical graduates only after World War II. Until after World War II there were no Residence Review Committees and only casual accreditation of programs in graduate medical education. The accreditation process has developed independently of medical schools or what we know now as modern health centers. This situation has led to growth without common direction, and it is not surprising that graduate medical education is currently not clearly defined.

From the synopsis provided by the staff, eight problems in graduate medical education are summarized (pp. 4-7). The "clear and evident problems" cited are as follows:

1. Availability of positions for domestic graduates;
2. The phasing-out of the foreign medical graduate;
3. Graduate physician--student or employee;
4. The role of the graduate medical faculty;
5. Governance and control;
6. Accreditation;
7. Specialty distribution; and
8. Financing.

REVIEW OF PAST MAJOR EFFORTS

Drs. Graettinger and Swanson reviewed the highlights of the following major studies and reports in graduate medical education:

1. Graduate Medical Education, Report of the Commission on Graduate Medical Education, Rappleye, W.C., Chairman, University of Chicago Press, 1940.*

2. Planning for Medical Progress Through Education, Coggeshall, L.T., Association of American Medical Colleges, April, 1965.*

3. The Graduate Education of Physicians, Report of the Citizens Commission on Graduate Medical Education, Millis, J.S., Chairman, American Medical Association, 1966.**

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*A copy of this report was distributed to each task force member.

**A summary of the recommendations of this report was distributed to each task force member.

4. The Role of the University in Graduate Medical Education, Proceedings of the 1968 Council of Academic Societies Conference, Smythe, C. McC., Kinney, T.D., and Littlemeyer M.H., Editors, Association of American Medical Colleges, September, 1969.*

5. Evaluation in the Continuum of Medical Education, Report of the Committee on Goals and Priorities, Mayer, W.D., Chairman, National Board of Medical Examiners, June, 1973.*

The Rappleye Report. Dr. Graettinger prefaced his review of the 1940 Rappleye Report by the following quotation:

> We trained hard, but it seemed that every time we were beginning to form up into teams, we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing. And a wonderful method it can be for creating the illusion of progress, while producing confusion, inefficiency, and demoralization.
>
> --Petronius Arbiter
> 210 B.C.

An abstract of the Rappleye Report, provided to the task force, is reproduced as Appendix B.

Dr. Graettinger reminded the task force that the environment in which the Rappleye Commission functioned, 40 years ago, was a time of post-flexnerian success in the establishment of a scientific base for medical education, and its concern was addressed to graduate medical education. The internship was not considered to be graduate medical education, but an educational opportunity to round out "training received during the medical course and which continues the clinical clerkship with enlarged responsibilities." The thrust of this report, which is apparent from the abstract, was that a year of clinical training to augment the clerkship experience was necessary to prepare one for the general practice of medicine or to enter graduate medical education, namely, a residency. Its effort was to set standards for the educational experience, primarily the internship, including consideration of the possibility that the internship should be a fifth year of medical school. Shortly thereafter, one quarter of the existing schools had or required an internship approved by the school. Another important note was that "hospitals that cannot make adequate educational opportunities available for interns or residents should seriously consider employing as salaried house officers young physicians who have completed their internships." There were about one half as many residencies as medical school graduates, only a small proportion of whom took residencies. This was at the time the specialty boards had established a three-year minimum for residencies. In both the internship and the resi-

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*A copy of this report was distributed to each task force member.

dency, the emphasis is on the relationship of the experience to medical school. The residency was visualized as requiring a third of its time spent in basic science, and it was suggested that the medical school be the place for that. It was recommended that hospitals unable to develop programs of true educational content for interns or residents should properly appoint salaried house officers.

The "Coggeshall Report." Dr. Swanson reviewed the "Coggeshall Report" of 1965 which was the blueprint for the reorganization of the AAMC between 1965-1970. Recommendations of that report influenced not only the change in the location of the AAMC from Evanston to Washington, but also the development of the council structure within the AAMC.

Throughout this report, the thrust is that graduate medical education must be considered to be a continuum with undergraduate and not a sequence of unrelated years. On page 38, at the beginning of the section labeled (5), one reads,

> A most significant implication of emerging trends is that medical education should, in the future, be planned and provided as a continuum--a continuous process with all elements carefully integrated and under coordinated leadership.

The recognition that the resident staff would become a major responsibility is mentioned several places in here, first on page 31, where it is stated,

> The medical schools and the teaching hospitals have assumed another cost--the cost of educating the intern and resident. Formerly, this was all 'free,' absorbed by the hospital and rarely appreciated in its magnitude or importance. The physician provided the education free, the indigent patient made himself available, and the charity hospital ward provided the space. These circumstances have largely disappeared, and the resident staff, although insufficiently compensated, are receiving increasingly large amounts.

The Coggeshall Committee also felt very strongly about the necessary relationships between medical education and the universities. On page 40, second paragraph, they speak to the need for increasingly close university ties:

> It is increasingly clear that the need of the future is for the university to assume comprehensive responsibility of medical education--extending to the pre-medical student, the medical student, the intern, the resident, and the practicing physician. While universities cannot, in the foreseeable future, be expected to exercise control over all intern and resident training, the greatest possible effort should be made to move in this direction. Only the university can provide the needed continuity of planning and enforcement of high scholarship standards. Only the university can provide the needed tie of instruction between research--the source of scientific advances--and practice--the means through which the true benefits of scientific advance are provided to the patient.

That statement, probably more than any other, caused a degree of polarization in attitude between the existing graduate medical system in the hospitals, the medical schools, and the universities.

On page 47, the committee is speaking to essentially the same point:

> A particularly important implication of emerging trends for the Association of American Medical Colleges is the need to encourage and assist member institutions in assuming responsibility for the full scope of physician education.
>
> The association should encourage the member university, as the best prepared and most proven sponsor, to extend its educational responsibilities to encompass not only the education of the medical student but the intern, the resident, the medical scientist, and the practicing physician. The association should take the lead in accrediting programs directed toward the continuing education of practicing physicians.

These are, then, some examples of the stance of the Coggeshall Committee that graduate medical education be a part of the continuum and that graduate medical education become a full responsibility of medical schools.

The Graduate Education of Physicians. Dr. Graettinger reviewed The Graduate Education of Physicians through the use of an abstract which he compiled. The perspective of this report is one of a decade ago. The concern of the report is that the general nature of graduate medical education is based largely on the same fundamental concepts that determined the characteristics 30 years ago, at the time of the Rappleye report. The areas addressed were as follows:

> Serious questions have been raised as to whether the rotating internship is not an unnecessary duplication of the clerkship experience. Similarly, questions are raised as to whether the straight internship is not an unnecessary year of residency training under another name.
>
> There has been an almost uniform trend for increasing numbers of graduates to enter residency training in one of the medical specialties so that currently the large majority of young physicians are identified with a specialty and fewer and fewer are available as family physicians.. . . As yet no serious effort has been made to determine even in general terms, the distribution of physicians within the differing fields of medical practice which would be optimal for the provision of superior medical service.
>
> There exists no satisfactory identification of the proper relationships of the three components--education, training, and service--to each other.

On the second page of this review is listed the situation with regard to accreditation of internships and of residencies. It should be emphasized that at that time there existed the Internship Review Committee which reviewed all of the first-year graduate medical education programs. This committee is now defunct. It consisted of representatives of the Council on Medical Education of the American Medical Association (AMA), the AAMC, the American Hospital Association (AHA), the Federation of State Medical Boards, and the field of general practice.

> The Flexner report gave medical education a timely and healthy push in the biological and biochemical direction. Growing scientific knowledge furthered the trend. The availability of large funds for biomedical research accelerated it. Medicine has been greatly strengthened by these developments. They should be supported and continued. The problem is not that these aspects of medicine have grown too rapidly. The problem now is to add a new dimension to the practice of medicine that will help to utilize this growth and to bring the practice of medicine up to its high potential. The needed new dimension is continuing and comprehensive care of high quality. Medical education must produce competent and broadly trained physicians to give that care.

Next were the recommendations which led to the Board of Family Practice and the accreditation of family practitioners. Dr. Graettinger underscored what they stipulated:

> First, simple rotation among several services, in the manner of the classical rotating internship--even though extending over a longer period of time--will not be sufficient. Knowledge and skill in the several areas are essential, but the teaching should stress continuing and comprehensive patient responsibility rather than the episodic handling of acute conditions in the several areas. . . . Second, some experience in the handling of emergency cases and knowledge of the specialized care required before and following surgery should be included. . . . Third, there should be taught a new body of knowledge in addition to the medical specialties that constitute the bulk of the program. . . . Fourth, there should be opportunities for individual variations in the graduate program. Fifth, the level of training should be on par with that of other specialties. A two-year graduate program is insufficient.

The Millis Commission recommendation regarding corporate responsibility follows:

> We recommend that each teaching hospital organize its staff, through an educational council, a committee on graduate education, or some similar means, so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibilities of particular medical or surgical services or heads of services.

Action was not taken on this recommendation. The commission also recommended

> . . . that the internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole.

The commission did follow through on this recommendation and also another recommendation

> . . . that state licensure acts and statements of certification requirements be amended to eliminate the requirement of a

> separate internship and to substitute therefore an appropriately described period of graduate medical education.

Dr. Graettinger commented that from his vantage point in the National Intern and Resident Matching Program (NIRMP), the repercussions of this are still distressing to the consumers--medical students and program directors.

The commission also recommended

> . . . that graduation from medical school be recognized as the end of general medical education, and that specialized training begin with the start of graduate medical education.

In the section entitled "Basic Residency Training," the commission recommends "that hospitals experiment with several forms of basic residency training, and that the specialty boards and residency review committees encourage experimentation." This has not been achieved. The general curriculum for the first year of graduate medical education has, with very few exceptions, not been accomplished in hospitals.

As discussed in the section "The Teaching Hospital," the commission recommended

> . . . that programs of graduate medical education be approved by the residency review committees only if they cover the entire span from the first year of graduate medical education through completion of the residency.

By and large, this has been implemented.

The commission recommended

> . . . that programs of graduate medical education not be approved unless the teaching staff, the related services, and the other facilities are judged adequate in size and quality, and that, if these tests are met, approval be formally given to the institution rather than to the particular medical or surgical service most directly involved.

This recommendation has not been implemented. What these two recommendations mean is that the hospital rather than the individual services is responsible for the quality of the program.

It is stated in "The Role of the University" that the responsibility for graduate medical education should not now or in the foreseeable future become entirely a university responsibility. "University hospitals are in no better position to provide all graduate medical education than they are to provide all of the hospital services that are needed." The commission viewed the university as an educator of teachers, a producer of new knowledge, and a very special concern was that it generated teaching materials, but the university is "the only institution in which medicine can find all of the intellectual partners it needs in developing the concepts and techniques of a broad program of health care."

The last section, "Supervision of Graduate Medical Education," points out the chaos which very much still exists:

> Admission to medical school is under medical school control.
>
> Admission to practice is a function of the individual states. The existence of much reciprocity and widespread acceptance of the National Board examinations as the equivalent of a state's own examinations does not lessen the state's authority or responsibility.
>
> Approval of an internship program is a responsibility of the American Medical Association's Council on Medical Education, aided by the Internship Review Committee.
>
> Approval of a residency program is granted or withheld by a residency review committee appointed by the Council on Medical Education, the appropriate specialty board, and, in some cases, a college or society of the appropriate specialty.
>
> Admission to an internship or a residency is at the discretion of individuals or departments of the hospital.
>
> Certification as a specialist is granted by an examining board consisting of members of the specialty.
>
> Who may practice in and use the facilities of a hospital is determined by the trustees of the hospital. Their decision is often based upon the physician's eligibility for board certification.

What was then proposed was a new organization, a commission on graduate medical education, which would largely be appointed by the Council on Medical Education of the AMA with recommendations from other groups. This was effected in a different set of fashions.

Within the section "Responsibilities of the Commission on Graduate Medical Education," it is suggested that the Internship Review Committee be abolished and recommended, finally, that "each residency review committee include a few members from outside of the particular specialty."

The Role of the University in Graduate Medical Education. Dr. Swanson identified this as the first activity of the Council of Academic Societies when in 1968 it convened a national meeting to consider the role of the university in graduate medical education.

Dr. Swanson expressed his view that the principal advantage of this book to the task force as a reference document relates to the several panels which worked as working groups during the course of the meeting and the questions that were addressed to them. These are reported beginning on page 111. The working groups addressed the following questions:

1. Who should control graduate medical education?

2. To what extent should the content of graduate medical educational programs be determined by the specialty boards?

3. Should residency training programs be controlled by the hospital or by the medical school?

4. Should there be a commission on graduate medical education?

5. What can university graduate medical education do better to meet the demand of the community for comprehensive medical care?

6. What is the elusive desirable physician?

7. Can the desired products of graduate training programs be defined?

8. What should be done about the internship?

9. Should there be standardized required periods of training as a first step toward specialization?

10. How should graduate medical education be financed?

The summary and conclusions begin on page 130. It is worth noting that the ideas expressed in 1968, almost a decade ago, have now become realities:

> The commanding position being taken by third-party payers in financing health care is a force which will virtually demand a different organizational interrelation between faculty, patient, and resident than that to which we have been accustomed. The conviction that a single standard of care should be provided all patients will interact with the forces mentioned above to produce new relations and responsibilities for both mature physicians and those in training. The drive for a more comprehensive pattern of care will profoundly affect the organization of hospitals. Rising costs, growing depersonalization of urban life, and growing recognition of the possibilities of ambulatory care are all additional forces moving medical education in all its phases toward new ground.

The six final recommendations of this group follow:

1. Universities should be urged to encourage their medical faculties to assume the same sort of responsibility for graduate medical education that they have for undergraduate medical education.

2. Universities must take the lead in encouraging innovations in medical education and must be especially concerned with adapting graduate medical education to take optimal advantage of rapidly emerging changes in undergraduate medical education.

3. Those agencies responsible for maintaining standards of graduate medical education must recognize that each university should be permitted to introduce innovations and that such innovations

must be permitted a fair trial.

4. . . . The agencies and organizations with major interests and responsibilities in graduate medical education should put together some single organization or commission to unite the now fragmented jurisdictions in graduate medical education into a single focus. This commission should have as one of its authorities the accreditation of programs in graduate medical education on an institutional rather than a departmental basis.

5. Changes do not occur automatically. These innovations will come about if those who are individually responsible for programs in graduate medical education and those who are interested in bringing about the changes called for during this conference pursue these goals for their own programs. If this is done, broad, multifocal support of a new order of things will emerge.

6. The Council of Academic Societies should develop programs to support the realization of the concepts which the conference advocated. The Association of American Medical Colleges should endorse these recommendations for restructuring graduate medical education, many of which were originally called for in the Coggeshall report.

As one might expect from the content of the "Coggeshall Report," there was a very strong emphasis on universities' corporate assumption of greater responsibility for graduate medical education.

Evaluation in the Continuum of Medical Education--Report of the Committee on Goals and Priorities of the National Board of Medical Examiners ("The GAP Report"). "The GAP Report" evolved at a time when the National Board of Medical Examiners felt it should consider reorganizing its goals and priorities. In it, graduate medical education was of major concern, as is demonstrated in the following discussions: specialty certification and specialty boards (pp. 34-37); changing aspects of graduate medical education (p. 45); intramural evaluation of achievement and learning (pp. 48-49); and qualifying evaluation (pp. 49-50). This concept led to the National Board's development of a comprehensive qualifying exam at the interface between undergraduate medical education and graduate medical education.

Final recommendations to the National Board of Medical Examiners begin on page 65. The GAP Committee recommended that the National Board be prepared to deal with medical education as a logical continuum and not as a series of disconnected phases.

At the conclusion of these presentations, Dr. Myers invited questions and comments from the task force. Dr. Medearis asked the group if there are important differences between today's circumstances and the circumstances prevalent when studies were conducted a decade or half a century ago.

A number of issues were named in response to his query. Among them were the following:

1. Specialty distribution;

2. Dissatisfaction with the current system of accreditation of graduate medical education; and

3. The role of the third-party carrier in graduate medical education.

NIRMP DATA REVIEW

Dr. Graettinger discussed data derived from the National Intern and Resident Matching Program. He elaborated on the following papers:

1. Graettinger, J.S. Results of the NIRMP for 1977 (Agenda Book, Tab B/N).

2. Graettinger, J.S. Graduate Medical Education Viewed from the National Intern and Resident Matching Program. J.Med.Educ., 51:703-715, 1976 (Agenda Book, Tab C/O).

3. Graettinger, J.S. Positions in the First Year of Graduate Medi- Education Obtained by United States Graduates in 1976 (Distributed at the Meeting).

In addition, he discussed the graphs in the Agenda Book under Tab D/P.

Over a four-year period, there has been an increase of 2,200 U.S. graduates going into the generalist specialties. The breakdown among the the various generalist specialties was also presented.

The problem of reliability of the data for the first graduate year (G-1) was raised. The support specialties--anaesthesiology, pathology, radiology, and physical medicine--are urging residents to have a broad G-1. Who shall provide this broad first year to persons then transferring at G-2?

Related to that problem, Dr. Myers added, is one that has to do with the manpower law requirements for primary care. Although it would appear that adequate numbers of individuals are going into internal medicine, pediatrics, and family practice, anyone who later transfers out of a primary care specialty will be subtracted from the quota. In effect, one is asking the primary care departments to prepare persons for service fields when they may not be training an adequate number in their own field. One solution might be to increase the number of training positions, particularly in internal medicine, and to a lesser degree in pediatrics, because as the population is getting older, the need for pediatricians will decline.

Dr. Dustan said that she had heard that young people are not so interested in family practice as they once were. To this, Dr. Graettinger responded that the Millis Commission cautioned against calling a simple rotation among services a family practice experience, rather than a cohesive kind of generalist, primarily ambulatory care-based experience. Dr. Reynolds reported that the difficulty has been in creating good, solid programs with good faculty. Whereas in internal medicine the increment of positions is practically entirely by augmentation of existing positions, in family practice the increment

is almost entirely the result of the addition of new programs.

Dr. Myers agreed with Dr. Reynolds. He found in the LCGME review of actions of Family Practice, Residency Review Committees (RRCs) approved programs seemed to be of two kinds--good programs which filled and had no problems and newly developed programs which might not have looked very good but were approved because family practice is a rapidly expanding new specialty. His experience in his own medical school has been that medical students know the difference between these programs. Once the good programs are filled, the medical students will go into something else rather than to go into one of the substandard new programs.

Dr. Reynolds commmented that there is always a group of people who do not know where they are going to go. They tend to end up in family medicine to sample types of programs for another year. The programs never know who is in that group of students. Then they go into other specialties. He suspects that this is always going to be true. Family medicine is not as clear a choice for many graduates, and it may be another 10 years before patterns are firmly established.

Dr. Swanson said that in debates regarding the last Health Manpower Act, aggregate data out of the AMA's file indicated that about a 10 per cent loss occurred in internal medicine between the first and second years. One might assume those were headed toward dermatology, neurology, etc.

Dr. Graettinger cautioned that a dangerous source of data, used to project health manpower, is the figure published for first-year residency types by the AMA each year. An individual starting into neurosurgery after five years of general surgery is counted as an R-1. Someone starting into ophthalmology or urology in a third-year is counted as an R-1. Not only is there a gross numeric overestimate, but also an overestimate of those fields in which two or three more R-1s are common, namely, in the surgical specialties.

Possible sources of data were discussed. These are summarized as Appendix C. The task force was to contribute additional ideas.

NATIONAL PATTERNS OF GRADUATE MEDICAL EDUCATION & ITS ACCREDITATION

A paper in which Dr. Swanson summarized the status of the accreditation body in graduate medical education, the Liaison Committee on Graduate Medical Education (LCGME) appeared in the agenda under Tab E/Q. Swanson described the genesis of the LCGME in a series of meetings beginning in the fall of 1972, which brought together representatives from the American Board of Medical Specialties (ABMS), the AAMC, the AMA, the Council of Medical Specialty Societies (CMSS), and the AHA.

The LCGME has had a significant impact and although it is by no means a free-standing commission--such as was recommended in the reports by Rappleye in 1940, Millis in 1966, and the AAMC in 1968--it is definitely a plenary body looking at graduate medical education holistically. This is in contrast to the way the RRCs were and still are approaching graduate medical education on a specialty-by-specialty basis. Although there is nothing wrong with the

RRCs focusing predominantly on their own disciplinary interests in the review of programs, to do that without an overview body looking at the totality of the effort in graduate medical education has been a problem. Another problem has been the propensity of RRCs to be very lenient in allowing programs to be on probation for periods of time sometimes equal to the length of time that the program had been in existence. Also, failure to look at institutional patterns has resulted in certain institutions having all programs on probation at the same time, clear evidence that something was wrong in terms of the institutional commitment to graduate medical education.

The development of both the CCME or the LCGME has resulted in the RRC's feeling somewhat threatened. In retrospect, one can say that the LCGME made some tactical errors by not clearly demonstrating early on that it would review broad principles from the standpoint of the consistency of the actions of the RRCs relative to their own standards and to one another rather than to make qualitative decisions about programs. This is being worked out slowly.

Reinforcing Dr. Swanson's comments, Dr. Douglas added that one of the earliest problems was that the authority of this committee was never clearly established in the minds of the people whose activities it would directly affect. Secondly, the committee had to begin operations with a staff situation which became more inadequate as time went on. Thirdly, the information system on which the evaluations are based is inadequate and archaic. The development of a new system for program evaluation must be done and it may take years to do it. To perpetuate the current one is simply to invite more problems and perhaps disaster. Finally, the whole experience of LCGME has made it critically clear that there must be representation from below in this effort. Otherwise the dichotomy will continue to exist, and it will split. Elaborating on his view, Dr. Douglas said that it has been shown rather clearly that the input from RRCs has been virtually nonexistent, a potentially very valuable source not only as information for discussion by the LCGME, but if one is interested in establishing, for example, the role of the university in governing programs of graduate medical education, on should start with the RRCs and the program directors. To try to do it from the top side--the universities and the deans--one will run into trouble in the affiliated hospitals. Working through the program directors and the RRCs, one will see a lot of issues differently.

Another resource document distributed to the Task Force was The Annual Report of the American Board of Medical Specialties, 1975-1976. Dr. Swanson said that he considered the specialty boards critical to the deliberations of the task force as being the uniquely American answer to the maintenance of quality in the private sector as autonomous, independent agencies developed between 1916 and 1970. The ABMS is beginning to establish broad principles and policies to which the certifying boards will adhere.

Dr. Myers asked Dr. Douglas if it was his opinion that the LCGME should be reconstituted to become a group of RRC representatives rather than those represented in the past or whether it should be both. To this question, Dr. Douglas responded that during Dr. Myers' tenure as head of the LCGME, the policy was adopted to invite annually the chairmen of all 23 RRCs to meet with the LCGME. A few of them raised rather difficult questions, but in general, it was an educational effort. In spite of that, when issues focused on the RRCs, problems developed--first in Obstetrics-Gynecology and later by other RRCs. The American College of Surgeons recently adopted a memorandum which proposed putting

the LCGME out of business. The American College of Obstetrics & Gynecology has issued a statement along the same lines. The best way to deal with this problem would be to have the LCGME constituted as a bicameral body so that RRCs can meet to discuss their problems preferably at the same time. All RRCs should be brought into the organization rather than simply talking at them.

Dr. Dustan expressed her view as a member of the RRC in internal medicine. Her RRC gets little information about the LCGME because its secretary is not very effective. Not only in medicine, but among many RRCs communications are poor.

Describing the system of residency review, Dr. Swanson said that for all practical purposes there was really no significant degree of immediate review and approval of graduate medical education prior to about 1946. In the 1920s, the AMA published lists of hospitals and names of programs and program directors where one might obtain graduate medical education. This list was expanded somewhat in the 1930s. For a while, there was no formal review, but approval was based largely on anecdotal data. After World II, Internal Medicine approached the Council on Medical Education of the AMA to utilize the AMA's resources to establish a committee for the purposes of reviewing and improving programs in graduate medical education. The RRCs for most of the specialties were established soon after that, although pathology did not form an RRC with sponsorship under the AMA until 1972.

Table 3 in the paper on the LCGME delineates the differing sponsorships of the RRCs. The potential sponsors are a certifying board and the Council on Medical Education, which are constant, and, in some instances, a specialty society. The size of the RRCs ranges from 4-12 members. As this system developed, the AMA devoted its resources to the provision of staff support through the identification of full-time staff members called "secretaries" to the RRCs. They were given some administrative assistance and secretarial staff.

Before the LCGME began to function, each of the secretaries staffed from 3-6 RRCs. Staff are responsible for arranging site visits and meetings and for collating data. One problem with the RRCs is that they functioned somewhat like the certifying boards: each had its own rules, its own set of data elements, its own system for collecting information, its own system for reviewing information, and its own system for making decisions. There seemed to be almost no communication among the secretaries or among any superbodies including a Council. The RRCs essentially maintain the autonomy concept of each specialty. The development of RRC policy is interesting. Technically speaking, the boards develop the certification requirements for each of their specialties. These are published from time to time, but usually, the most recent one would be available only from the boards because the requirements change almost without warning. The only place they are commonly published is the so-called "Green Book," the Directory of Approved Residencies. If the certifying standards established by the boards change, the RRCs are expected to modify their programs accordingly in terms of special program requirements. The special requirements and the general requirements make up what is called the "Essentials of Graduate Medical Education." The general requirements, up to this time, have been the responsibility of the AMA Council on Medical Education but now are the responsibility of the LCGME. The special

requirements are drawn up by the RRC but must then be approved by each of the sponsoring organizations of the RRC. An inordinate delay results because of the AMA approval process which must be cycled through the AMA Council on Medical Education, AMA Board of Trustees, and AMA House of Delegates. Some of the frustration which has been blamed on the LCGME has been generated by the AMA approval process. Once the special requirements have been approved by the sponsoring organization, they must come to the LCGME for final approval. The "general requirements" for graduate medical education are currently in the process of being rewritten with an emphasis to be placed on the institutional responsibility. Dr. Swanson concluded that at the present the policy problems of the RRCs, as far as the development and expeditious approval of any changes, are such that the opportunity to make graduate medical education flexibly changeable are severely limited. He feels that the task force must consider this.

Dr. Myers asked Dr. Swanson to say something about the methods of review of programs in the field.

The general requirements, Dr. Swanson reported, must be approved by the five parent bodies that sponsor the Coordinating Council. These five agencies have separate jurisdictions. The bylaws provide that if any one of them disapproves of any CCME action, then it is disapproved. If any significant changes in the general requirements were not accepted, this could be a problem.

Dr. Swanson went on to describe the review process. AMA field staff, which consists now of twelve individuals, travel around the country carrying out site visits on programs that are up for review. Every three years, every program is to be reviewed. There are about 4,000 extant graduate programs. From 1700-2200 programs are therefore reviewed annually. The data base is directed toward the specialty for the program rather than toward the institution. The review by the field staff is often carried out in a fashion which would allow an institutional review. For example, last fall a field staff member moved into Birmingham, Alabama, and for four weeks progressively reviewed approximately 14 programs. The review of each program was unrelated to the others. The RRCs have been increasingly uncomfortable with the field staff. The field staff reports have not been well done and at times are illegible.

Dr. Douglas added that the three-year cycle of accreditation depended in large part on the availability of field staff and their travel schedules. This leads to a lot of flexibility. Field staff are under the supervision of the full-time people who serve as secretaries for RRCs. They know that the field staff do not always do a good job. Before the existence of the LCGME, RRCs had virtually absolute power, and the only act that they ever had to have approved by another body was the recommended change of requirements or policy. The RRCs reviewed second-hand reports by someone who might have been tired and reviewed a stack of documents 1½ inches thick and then said, "Your are approved for three years" or "You are disapproved." Discussion would then be summarized by the fulltime secretary, and he was the only one who could communicate with the program director, and he was the only one the program director could address if he wished to challenge a statement that had been made. This is part of the intolerable, rotten communications that have been going on since 1955, when these things were organized. It is incredible that it has gotten this far without serious trouble, but until

quite recently, there was literally no appeal process to a decision. The LCGME has instituted an appeal process.

Medical school accreditation, according to Dr. Swanson, has been on a seven-year cycle until quite recently. Now the maximum approval is for 10 years. He explained that the number of visits that universities must sustain, both from the standpoint of regional accreditation for the overall university function and the growing number of specialized accreditation bodies, is causing a lot of static from the standpoints of expenditure of resources, faculty time, etc. One of the reasons that the LCME has gone to the 10-year cycle is in an attempt to coordinate its site visits with those of the regional accrediting bodies.

In discussing what might be an optimal length for graduate education, he said that since 90 per cent of the graduate medical education accreditation involves universities, five years was an attractive possibility because this could be coordinated every 10 years with the LCME accreditation. Expenditures could be reduced by lengthening the terms of approval. The LCGME has not yet tackled this question.

Dr. Myers reported that well over half the time of RRCs is spent on 10 per cent of the programs. The task force might look at what might be a proper system for residency programs.

In response to Dr. Myers' question as to whether there would be any future for institutional accreditation, Dr. Swanson replied that his personal view was that institutional accreditation would be infeasible at this time.

INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION, 1971-1975

Dr. Swanson described the several items on institutional responsibility under this agenda item.

The AAMC's position, published in 1971, called for institutional accreditation without regard to subaccreditation of programs. This caused a great deal of anxiety, particularly among some of the specialty societies. However, the statement which was passed by the CCME and its five parent organizations in 1974 is not dissimilar, and that statement is the basis for revising the general requirements. This essentially says that an institution that wants to sponsor graduate medical education must have internal mechanisms for quality control, program planning, and clear mechanisms for the commitment of resources of education.

In the "Implications" document, developed in 1971 by Cheves Smythe et al, the pitfalls are well documented.

The "Guidelines" document, developed in 1973, was designed to guide faculty in ways to organize for assuming a broader corporate responsibility for graduate medical education. Various institutions have found this useful.

Finally, results of an AAMC survey assessed the extent to which academic medical centers might have progressed in this embracing this concept.

This task force represents the first time since 1974 that the AAMC has had a committee on graduate medical education.

Dr. Swanson said that he would like to get the task force opinion on whether a school survey should be planned. He invited Dick Knapp to comment.

Speaking of corporate responsibility, in which there is no corporate entity, Dr. Knapp said that it is his impression that in "first-class" affiliated hospitals, the department chairman would rather keep the sophisticated programs in his own institution and give the primary care to an affiliated institution. On the other hand, pressures are exerted on administrators to develop sophisticated services. A self-destructive confrontation takes place as a result.

Dr. Knapp suggested that one needs to define all the advantages of institutional responsibility and strengthen those advantages in a way to move things forward. The negatives are quite apparent, but the advantages are not. When a large amount of money is from a source for which an individual has fiscal responsibility, he will want to participate in one form or another in decision-making.

According to a recent AAMC study on hospital affiliations. Mr. Keyes added that programs at the graduate level are seldom single institution programs, but there is involvement of large numbers of institutions--and yet the involvement of the corporate mechanisms of those institutions is still very loose.

Dr. Knapp concluded that the most impressive development with which he was acquainted was that at Northwestern where there seems to be a high-level satisfaction.

Dr. Graettinger noted that institutions had no impetus to assume such responsibility from the specialty boards of the ABMS and the LCGME. He suggested that if the LCGME were to introduce a residency review committee for all of the first and second year programs offered by each academic medical center so that the whole institution would be looked at, there might be incentive to do something about corporate responsibility.
To this comment, Dr. Myers responded that the 1974 statement of the Coordinating Council (Tab G/S in the Agenda) is the policy of the LCGME and is approved by the ABMS. He added that not much had resulted from it. The policy was clearly adopted.

CLINICAL MEDICAL EDUCATION

Referring to his paper on this topic, Dr. Graettinger indicated that its purpose was to raise the question of sequence in the development of the physician. Faculties have never--either at the undergraduate or graduate levels--defined broadly the competencies to be exhibited at each step. The GAP report suggests that this should be done. Considering the general clinical year, one must ask if one year of clerkships and one year of electives before specialty training are adequate. This is in contrast to the two years of required courses and general year of training previously required before a residency. Dr. Graettinger said that the impact of the technological revolution on the educational process disturbed him. He asked where it is in clinical medical education that the aspirant physician becomes responsible for those professional attributes which must be learned as an apprentice in

nature and where is the ability to apply inductive reasoning and medical decision analysis that deal with clinical problems. Much clerkship and early residency education involves the practice of the specialty rather than the learning of the approaches. Another issue concerns the realtionship between the school and the hospital. The school has as its first priority educational commitment, but the "classroom" of the second phase--graduate medical education--is the hospital whose first priority must be service. To write affiliation agreements, one must fully explore the educational commitment of the hospital. The role of the department chairmen is crucial to a true sequence of clinical medical education since the same individual is often in charge of clerkships, is program director in one or several hospitals, and is also concerned broadly with health care. In considering different kinds of affiliations vis-a-vis corporate responsibility, these considerations are crucial.

OTHER STUDIES

Summary recommendations from a report based on a study initiated by the U.S. Government Accounting Office (GAO) was distributed. GAO does studies at the request of the Congress or a specific congressman, but, as was the case with this study, they may initiate their own studies. GAO launched this study about 18 months ago. A principal conclusion is that something needs to be done about physician manpower planning. This report relates to specialty distribution. A companion study on geographic distribution will be issued within the next few weeks. The major recommendation and the one of greatest interest is that the HEW Secretary enter into the discussions with the Coordinating Council on Medical Education to determine whether the Coordinating Council would be willing and capable of conducting studies relative to predicting physician needs. A little more specific than that, they emphasize (p. 108) the control of specialty distribution utilizing the accreditation powers to modify the number of available positions of the CCME and the LCME. The Association has taken a position that accreditation, per se, should not be a mechanism for the control of numbers. Rather, the resources available for education and the plans for education should be judged on their merits, but the number who should be entered should be developed by some other body.

Dr. Kennedy commented that four of the five parent organizations of the CCME are strongly in favor of defining needs for physicians by specialty. Everyone is impressed by the increased production of generalists over the past several years before any kind of regulation began. The CCME would be willing to undertake on a continuing basis whatever data collection efforts are necessary to do the analytical work that will result in some proximate definitions of an ideal need for numbers of various types of specialists and generalists.

Dr. Swanson opposed any commitment, at this time, by the CCME to a hard regulatory system. According to the GAO report, no specialty organization believes its manpower needs are being met. This would seem to point up the need for the CCME to study disciplinary needs.

Dr. Douglas cautioned that although the disciplines may not be able to accurately assess their own needs, that is no evidence that the government is capable of doing any better. He contends that a methodology for each of the disciplines does not exist. Another problem is that one cannot predict the future in terms of demands. He believes that no national system can exist in the present state of affairs. First, one would have to decide what kind of system one wants.

Dr. Myers added that the experience in Great Britain has shown that so many

variables will result in tremendous errors in the predictions. Dr. Graettinger observed that health care itself is a bottomless pit. The questions are how many physicians, for what, and for whom? The public, in his opinion, will never feel that there are enough physicians.

Dr. Medearis said that another force is state legislation. In Ohio, legislation pending would determine location, number, and duration of primary care residencies.

A number of studies were mentioned as possible resource documents for the task force. These are listed in Appendix C.

TASK FORCE APPROACHES

During the second day of the meeting, the task force discussed various approaches that it might pursue, identified specific problem areas that it might study, and defined other studies as resource materials. Opening the discussion, Ms. Gutmann referred to the synopsis under "Clear and Evident Problems," Question 3, page 4: Graduate physician--student or employee? She contended that housestaff function in several capacities, which are not mutually exclusive: teacher, student, and service provider. None of the functions can be considered in isolation of the others. She also suggested as an addition to the problem list, perhaps as a subset of one of the others, the stipulation of the manpower act about reduced and flexible time schedules.

Primary areas of concern that Dr. Myers tentatively put before the task force were the following:

1. The educational strategy and organization of graduate medical education;

2. The field of accreditation and governance of graduate medical education; and

3. The financing of graduate medical education.

Dr. Homan shared with the task force his understanding that in the near future legislation will mandate that every service patient must be a private patient. In surgery, that means that there's going to be less opportunity for surgical residents to learn how to do surgery, and surgeons will graduate not knowing how to do surgery.

Dr. Myers said one solution in this regard is that in an educational system, the attending surgeon talks to the patient about who is to do the technicalities of the operation and thereby obtains permission for the chief resident or whomever to do the surgery.

To Dr. Myers' question of whether this was feasible, Dr. Homan replied that it is a rare surgeon who, when the patient says, "You're going to do my surgery, aren't you?", has the courage to say, "No, in this institutional teaching program, the residents do it." Most would say, "Okay, I'll do it."

Dr. Swanson alluded to another problem that is compounding this dilemma.

That has to do with the expedited passage of patients through hospitals these days. The patient comes in one day, gets labwork the next, and is out from the surgery the following day and never really gets a chance to develop a relationship with the residents. The opportunities for the patients to learn to know the housestaff and to gain confidence in the fact that the senior resident is becoming as least as good a surgeon as the surgeon he selected no longer exists.

Dr. Graettinger commented that at Presbyterian-St. Luke's Hospital for a decade every patient has been under the direct supervision of an attending physician in a single standard system regardless of the private or public source of payment.

One partial solution, according to Dr. Myers, used at Pittsburgh for over forty years, is to make the higher level residents staff and handle them just like any other surgeon or physician on the staff. This way, they have always been able to take care of a sizeable coterie of private patients as their private physician. It is only a partial solution. Since considerable income results from this arrangement, it can pay for a considerable malpractice premium for the resident.

Dr. Swanson wondered if one task should be to try to get some sort of assessment of how acute the problem of an inadequate or a diminishing patient population is as a factor in graduate medical education, or, in clinical medical education. His reason for this suggestion is that the LCME is now saying that the limiting factor in medical education these days appears to be more and more the issue of the availability of a patient population for educational purposes, rivaling the old problem of how big were the laboratories or how big were the lecture halls.

Dr. Foote said that the Millis Report recommendation to turn the internship into the first-year residency has forced the fourth-year medical student to decide what he or she wants to do at that time and not have another year to try to figure out what it is that he or she wants to do. For example, to be fair, students may admit that they want to be ophthalmologists, but that, since a year of general training is required, they will take surgery, or medicine, or family practice for a year. In that case, their matching potential will drop and they will be forced to take an inferior program. On the other hand, one may profess to want to do medicine for the rest of his or her life (knowing that he or she wants to be an ophthalmologist), sign for the program, and when approached in November, say, "No, I agreed to go to the ophthalmology program in Barnes." This puts both the fourth-year medical students and programs in a bad position. The turnover in interns is higher than ever because of this. She suggested that the task force consider whether the step that the Millis Report shoved us in the direction of was not a mistake and whether we should not have general internships again.

Concurring with the position which Dr. Foote stated, Dr. Swanson commented that possibly the effort to reduce the length of medical education may have resulted in putting students in a position to make decisions that they are not yet mature enough to make.

From the standpoint of an internist, Dr. Myers said that his experience has been that the majority of medical students know in their third or fourth year the field that they wish to enter. In that sense, the Millis Report and renaming the internship have not changed anything at all. The undecided students

who need the extra year constitute the minority. This does not justify returning to the rotating internship.

Dr. Foote then raised the issue of the disadvantage of people going into psychiatry with patient contact who have not had an internship experience. According to Dr. Swanson, the psychiatrists now require a broad year, but that results in the problem of finding a broad year. Ms. Gutmann named the problem of moving families. Dr. Myers pointed out that in internal medicine, students cannot move from one program to another because the programs into which they might want to move would be totally filled with their own products. No latitude is possible.

Dr. Myers reported that in internal medicine, some program directors now divide the content of R-1 into "categorical" and "diversified." If they have 16 positions, four may be diversified and 12 categorical. The residents are handled alike except for some difference in scheduling. Dr. Graettinger added that medicine and surgery are opposite in this regard. The majority of programs and positions offered in the primary care specialties are categorical, but in the surgical specialties they tend to be diversified.

Since 1975, the number of diversified programs has decreased steadily. In the surgical specialties, there are few programs and they are essentially all diversified or C-starred. Programs such as "first year of neurosurgery" or "first year of otorhinolaryngology" are diversified. Their number of first-year offerings is slowly growing. Eighty percent of the programs in the surgical specialties do not appear as first-year programs. Dr. Swanson commented that the rare instance in which individuals cannot make up their minds about careers and have to spend one year extra in graduate medical education may be preferable to pressuring them to make a career decision. Much of the confusion relates to the lack of rational discussions among the RRCs and a body that can discuss how best to deal with this transition. The certifying boards get together, change their requirements, and pass on to the RRCs the need to change the special requirements for training in that specialty; but they do this strictly along disciplinary lines. They never cross over and talk with anyone else. In drafting the new "Special Requirements," an attempt will be made to avoid totally making directives regarding the content of the R-1 year, rather saying that the "Special Requirements" of each board must reflect the R-1 year and that these, then, must be made consistent with the realities of the system. That will take time, but that will tend to shake out some of the current inconsistencies.

One individual noted that although the extra year might not be bad from the student's point of view, if the student uses up a slot, he might use resources unnecessarily. To this view, another said that they may be necessary for some people. Although the fourth year may be elective, students choose the same kind of program they had when it was required, Dr. Myers offered. Ms. Gutmann said that that points out the need to have quality assurance. Dr. Myers agreed to that comment. From the "Green Book," he feels it is evident that many of the institutions offering the Flexible R-1 are the institutions in the borderline or substandard 20 per cent that he had mentioned before. Whether they offer flexible. straight, or categorical is of no consequence because those programs are not good. It is much easier for them to deal with individuals in flexible programs than in straight.

Dr. Myers reminded the task force that the CQE is something to which attention

will have to be paid because there will be continuing pressures that one of the requirements for the transfer from undergraduate to graduate medical education will be the passage of the CQE.

Responding to a question by Dr. Douglas, Dr. Myers said that he thought that the CQE should be handled much as Part II of the National Boards is handled for domestic graduates. Most take Part II of the National Boards in the fall of their senior year. In the event that they fail, they have an opportunity for corrective education through the rest of that year and may retake it the following spring. By current standards, very few domestic graduates will have trouble with the CQE. Dr. Myers' opinion was that the CQE would stimulate the students. Because the same standards will apply to the FMG, the situation is apt to differ markedly from the domestic failure rate. But a Visa-Qualifying Examination is being developed to meet the requirements of the recent law. The predictions are that the Pass rate of FMGs on that Equivalent Exam for Part I and Part II of the National Board is going to be between 15-20%. From the standpoint of the GAP Committee, the CQE was looked at as a uniform scheme for the purposes of determining whether or not there was reasonable minimal competence established by the student. The question was raised as to what will happen to programs that are staffed by FMGs now and are going to be in trouble when the law goes into effect limiting the FMGs in this country.

Dr. Homan said that he knows a number of excellent FMGs, but they are not particularly learning anything. Dr. Myers added that a number of NIH (National Institutes of Health) programs also fall into that category.

Data on where FMGs go from graduate medical education would be useful according to Dr. Swanson. Ways in which their practice patterns may differ from domestic graduates could be examined.

According to several, some of the programs are candidates for upgrading in order to meet the requirements for domestic graduates as well as the proper component of FMGs for whom an educational experience should be provided. Two problems are involved in this transition. First, the upgrading is expensive. Secondly, some institutions do not want anything to do with academic medical centers because they lose certain of their autonomy that way. The only way to upgrade these institutions is to have some relationships with an academic medical center. The task force eventually will need to consider the principle which some have enunciated--That all programs in graduate medical education in this country should have some sort of affiliation with academic medical centers. Dr. Jason's impression was that if many programs are upgraded, there may be too many qualified programs in relation to the number of MDs needed for the U.S. graduates and the allowable percentage of FMGs. First, Dr. Graettinger suggested one must define the manpower needs of the nation--how many and what kind. Having answered that then one might see if too many MDs are being educated at the undergraduate level. At the present, there are no data on that.

Dr. Myers admitted that he was accepting the domestic output as being proper, which might not be the case. But, if it is proper, the number of acceptable positions in graduate medical education is about in balance with the output. This means that there is no margin. Therefore extra positions should be created because the output of medical schools is continuing to rise. This can be done by upgrading some of these poor programs that over the years have been unable to attract any domestic graduates; or another way to do it is by adding persons

to the good programs. A way to upgrade the programs is to close a few down so that it is more noticeable generally that that can happen.

Dr. Myers felt that the transfer of positions from surgery to the primary care specialties would be a tough problem. He again referred to the fact that most of the graduate medical education positions that the FMGs have filled have not been suitable for domestic graduates. For this reason, unless the positions are upgraded, the reduction of FMGs may have a negligible effect on training opportunities for domestic graduates. In internal medicine, good students will not take substandard programs, and those who do will not meet the specialty board standards. About 20 per cent of the programs in internal medicine should be upgraded. A certain portion should be upgraded in order to meet the domestic needs particularly in the primary care specialties.

Dr. Swanson observed that FMGs also disproportionately occupy certain specialties, such as pathology, anaesthesiology, and PM&R, and radiology to some degree. If one looks at an institutional base for graduate medical education, there are going to be instances where the issue of how you provide educational milieu in a department which no longer has the opportunity itself to be an educational department because it no longer has any trainees. He cited in particular neurology and physical medicine. The problem will be how to recruit a staff to be part of an educational system who no longer have the opportunity to reproduce their own kind.

Based on his personal experience, Dr. Douglas contended that it is hard to make a quality judgment that a program is bad. He felt that some attention should be given to mechanisms for program evaluation to include setting up requirements for weak programs. Dr. Myers pointed out that, over the years, dozens of programs essentially have had nobody certified by the American Board. That would be an objective criterion, although that does not apply to all FMG programs.

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TASK FORCE ON THE SUPPORT OF MEDICAL EDUCATION

The mandate and membership list of this Task Force appear on the following pages. The Task Force held its first meeting on October 5-6, 1977. Invited guests included Senator Edward M. Kennedy at breakfast, Representative Paul G. Rogers at lunch, and Ms. Ruth Hanft, recently appointed Deputy Assistant Secretary for Policy, Services Research and Statistics at DHEW in the evening. These officials responded to the Association's request to forecast the attitudes likely to prevail in their respective arenas when the health manpower legislation comes up for renewal. Each expressed continued willingness to cooperate with the AAMC in the emerging dialogue on this subject.

Working groups were formed to develop papers on: the relationship of the Federal government to the medical school and the rationale for federal support; the character of and need for financial support in medical education; the number of physicians needed by the nation and their appropriate distribution by geography and specialty; the role of the medical school in the containment of health care and health education costs; and special initiatives for inclusion in proposed legislation. The review of the initial reports of the working groups is scheduled for June of 1978.

MANDATE OF THE TASK FORCE ON THE SUPPORT OF MEDICAL EDUCATION

At the 1976 Annual Retreat of the Executive Committee of the Association of American Medical Colleges, the recommendation was made, and subsequently adopted by the Executive Council, that a Health Manpower Task Force should be appointed with the principal responsibility of developing the Association's specifications for the statute to replace the current health manpower legislation.

The modern history of health professions education legislation dates to 1963 when the Federal Government agreed to facilitate the production of physicians, by enacting a federal student assistance program and matching educational facilities construction grant program. Beginning in 1968, federal subsidization of the first in the form of basic improvement grants and later (in 1971) as formal capitation awards, to help defray the increased institutional costs associated with adoption of a national policy to expand the number of physicians. The general principles embodied in earlier legislation were renewed by the Health Professions Educational Assistance Act of 1976 (P.L. 94-484).

Support has been direct, through capitation, construction , and special project awards, as well as indirect, through student assistance and other less obvious forms, derived from health care and biomedical research income. The specific instruments of direct support have included: scholarships for undergraduate medical students, National Health Service Corps scholarships. loans for medical students under several different programs, special projects grants for a wide variety of purposes, financial distress grants, start up and conversion grants, construction grants, and construction loans.

P.L. 94-484, the current health manpower legislation, expires on September 30, 1980 (the end of fiscal year 1980). It would normally be expected that renewal legislation would be considered by Congress during calendar year 1979, so that a new bill could be passed approximately one year before the expiration of the current law. This timing will require the Task Force, while completing its work by late 1978, to anticipate both the effects of the current legislation, and the needs and desires of medical schols in the 1980-81 academic year and thereafter. Further, the Task Force will have to make assumptions about what will be the intent and role of Congress in directing health policy in this country at the time legislation is formulated, including the possibility that the first stages of National Health Insurance could have been enacted by that date.

Subsequent discussions between the Chairman of the AAMC, the Chairman of the Task Force and the AAMC staff have defined somewhat more precisely the mandate of the Task Force: to develop a broad strategy for the future course of medical education; and within this strategy, to design a set of specifications for Federal legislation. While the major forces of the deliberations of the Task Force will be on the undergraduate component, the context of its discussion will surely encompass the total system---undergraduate and graduate---for medical education, including all participating institutions, namely; schools, hospitals, clinics and other entities. A more appropriate title is the Task Force on the Support of Medical Education.

Several sets of questions seem central to the function of the Task Force.

- What is the appropriate role for the Federal Government in medical education in 1980 and thereafter? Should it be limited to financial support? Are there other possible -- and desirable -- roles? How can the Federal role proposed by the AAMC be rationalized? Are inappropriate Federal roles likely to emerge? What criteria determine propriety?

- If financial support is an appropriate Federal role and responsibility, what forms should it take, to what purposes should it be directed, in what "packaging" should it be wrapped? Should traditional categories of support---for construction, student assistance, operating expenses, special projects---be proposed, or is some alternative framework and set of specifications more desirable?

- How should Federal policy be interfaced with that of the several states? How can compatability be maximized and conflicts---for example, in the requirements which must be met to qualify for capitation support---be minimized? Could a Federal role be defined in which the states could participate?

- What would be a strategy to treat holistically the Federal financing of both undergraduate and graduate medical education

- What would be the consequences for the schools of a decision that Federal financial support was inappropriate? On what grounds could such a position be rationalized?

The Task Force's mandate is formidable, but critical to the future of medical education and its relationship to the Federal Government. The AAMC will endeavor to provide it full staff support to enable it to fulfill its responsibilities with thoroughness and speed.

July 11, 1977
AAMC/DPPD

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