association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

ANNUAL BUSINESS MEETING
MONDAY, OCTOBER 27, 1980
2 p.m. – 5 p.m.
GEORGETOWN EAST & WEST
WASHINGTON HILTON HOTEL
WASHINGTON, D.C.

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

COD SPRING MEETING

March 29 - April 1, 1981

The Broadmoor

Colorado Springs, Colorado

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
ANNUAL BUSINESS MEETING
Monday, October 27, 1980
2:00 pm - 5:00 pm
Georgetown East & West
Washington Hilton Hotel
Washington, D.C.

AGENDA

I. Call to Order

PROGRAM SESSION

"Academic Research and the Federal Government:
An Appraisal of the Relationship"

Dr. Cornelius J. Pings, Director
National Commission on Research
Vice Provost & Dean of Graduate Studies
California Institute of Technology

BUSINESS SESSION

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
SPRING BUSINESS MEETING

SESSION I
Wednesday, April 9, 1980
5:30 pm - 7:00 pm
Biscayne/Inverrary Room
Hilton Inn & Conference Center at Inverrary
Fort Lauderdale, Florida

MINUTES

I. Welcome and Overview of the Meeting

Dr. Bondurant opened the meeting with a welcome to the deans and their guests, specifically welcoming the deans of the Canadian medical schools and encouraging their participation in the program. He also identified the chairmen of the respective Councils and the Distinguished Service Members who were in attendance. He introduced the new deans who were joining the Council for the first time. He reviewed for the group the schedule and format of the meeting which would include business sessions on Wednesday evening and Saturday morning and program sessions on the next two mornings. Dr. Bondurant then provided an overview of the program sessions which evolved from the presentations and exchange between Dr. Dan Tosteson and Dr. Richard Moy at the last Spring Meeting. Finally, Dr. Moy briefed the Council on the second segment of the Friday morning program. He urged members to give thought to how they would like to structure the discussion session.

II. AAMC Position on Health Manpower Legislation

Dr. Ed Stemmler began by summarizing the AAMC's principles on health manpower. First, he explained that the Association was supporting unrestricted institutional support, arguing that unrestricted funds provide those funds by which schools can initiate innovation and maintain programs in the national interest. Second, the concept of special projects is supported. Since there are certain projects that should be identified as being of particular national priority and since such a diversified group of schools could mount those projects, those schools ought to be enabled to undertake programs suited to their particular capabilities through compensation for the costs they incur. Third, the Association takes the position that students should not be denied access to medical education because of financial need.

The AAMC opposes a condition governing eligibility for institutional support appearing in Mr. Waxman's bill. This provision requires schools to take responsibility for shaping residency programs so that a large percentage of residents would be in primary care residency programs during the next three fiscal years after subtracting, at the first year the third year levels, those entering the medical specialties. The AAMC disagrees strongly with this provision because the medical schools are being asked to take responsibility for residency programs and positions over which they have no control. Additionally, participation in primary care training is increasing; this demonstrates that government intervention is unnecessary to achieve the desired outcome. Furthermore, the AAMC prefers to speak about primary care services that are delivered by a variety of physicians rather than a primary care physician. Finally, the AAMC supports the position that the National Health Service Corps not be associated directly with the programs that support education because less and less money is available to support other programs under that same authority.

Dr. John A. D. Cooper presented his perception that the likelihood of a manpower bill passing this session is very remote. There appears to be a greater probability that there will be a simple extension, with a reduction in the authorization limit for capitation to be tacked on to some other bill that goes through the Senate. Dr. Cooper solicited the opinions of the members on whether or not they would support an authorization limit of $750 per student if there were a one year extension. There was a lengthy discussion by Council members on whether or not to accept the $750 or not ask for any specific dollar amount. The group expressed divided opinions and urged Dr. Cooper to use his wisdom, together with his own sense of the group's direction, in negotiations on this matter.

III. <u>The Health Research Act of 1980 (H.R. 6522) and The Health Science Promotion Act of 1979 (S. 988)</u>

Dr. John Sherman provided an update on the status of this bill which would renew the expiring authorities of the heart and cancer institutes of the NIH. Under the current rules of Congress, those authorization bills must be passed by the end of the first part of the budget period, May 15, in order to assure an appropriation for the forthcoming year. The bill is always changing and each new version attempts to correct some of the obvious errors uncovered in the previous bill, only to add some additional errors. One of the interesting features of the entire process is the lack of any major outpouring of concern about this bill from either categorical or more generic biomedical research interests.

The Senate bill, S. 988, has remained unchanged over the past several months while the House bill has been changed in several comparatively minor respects. The major provisions still remain troublesome: the closure of the open-ended authorization, the two new roles for advisory councils, 1) review of contract, research contract and procurement

proposals over $50,000, and, 2) the review on a project by project basis of the intramural research program. The AAMC's recently developed strategy would encourage the Congress, particularly the full committee in the House, to merely renew the expiring authorities for heart and cancer. The other provisions could then receive more careful study at a more appropriate pace. Failing that, it would be desirable to oppose at least the closure of those open-ended authorities while renewing the expiring ones.

IV. Report of the AAMC Committee on Clinical Research Training

Dr. Morgan summarized this report which had already been distributed to Council members. The report evolved from an ad hoc committee appointed by the Executive Council to address the widespread and growing concern about the decreasing numbers of physicians entering research and academic careers. The report includes data which documents this decline.

The committee recognized two of the most critical points in attracting physicians to research and academic careers each year: the early days of medical school and the second and third years of residency training. Recommendations to stimulate greater interest in these areas included the introduction or support of research experiences for medical students, curriculum changes and support for special training programs.

V. Adjournment

The meeting was adjourned until Saturday morning.

SESSION II
Saturday, April 12, 1980
8:30 am - 12 Noon
Biscayne/Inverrary Room
Hilton Inn & Conference Center at Inverrary
Fort Lauderdale, Florida

MINUTES

VI. Report of the Chairman

Dr. Bondurant began by altering the order of the agenda somewhat to accommodate the presenters travel plans. He then briefly shared a number of observations and comments on several issues.

First, he reported that the AAMC budget called for a 3.7% increase in expenditures for the next fiscal year. The item with the greatest increase has been in travel costs for the Association.

Secondly, Dr. Bondurant informed the group that there would be a joint meeting of the Executive Committees of the AAHC and the AAMC later in the month in Chicago. This evolved because of the extensive discussion over the years regarding the nature of the relationship between the two organizations.

Thirdly, Dr. Bondurant brought to the attention of the group a concern brought by the Society of Medical College Directors of Continuing Medical Education. This group of associate deans for continuing medical education is interested in a closer relationship with the AAMC, particularly the Council of Deans.

Finally, Dr. Bondurant referred to the two resolutions contained in the agenda. First, the resolution on the ranking of medical schools by the magazine, "Private Practice" was adopted by the COD Administrative Board. Dr. Bondurant asked for some action on this by the full membership. The COD then moved to accept the following motion:

The AAMC Council of Deans repudiates the concept, methodology and results of the ranking of medical schools conducted by the magazine Private Practice and reported in its March 1980 issue. The concept of identifying "the ten best and ten worst" of the nation's medical schools, all of which are accredited by the Liaison Committee on Medical Education, is both repugnant and mischievous. All provide quality education. Each is a complex institution with a variety of missions including different mixes of research, patient care, and community service. Any overall rating which fails to account for this complexity, and the diversity of

objectives and the approaches used to accomplish them, is a gross distortion which does a disservice to the American public. Several fine institutions which are admirably serving locally and institutionally defined objectives are maligned by this exercise.

The second resolution referred to a communication received by each student affairs dean setting forth the policy statement of the House of Delegates of the AMA on due process for medical students. Although this was evidently an internal error in the AMA, the Administrative Board adopted it in order to have a statement about the proper relationship between academic policies and internal governance of academic institutions. The COD adopted the following resolution:

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

In the final item of his report, Dr. Bondurant relinquished the floor to Dr. Ted Cooper who presented further views on the Health Research Act of 1980. Dr. Cooper's recent work on the bill had provided him with a point of view emphasizing several things: the prevalent notion which existed that this bill is rather innocuous, a routine piece of legislation; the prevalent notion that NIH and Dr. Frederickson had no problems with the proposed piece of legislation; the prevalent notion that since it was not directly affecting funding levels, it was a harmless piece of legislation; and the prevalent notion that there was no alternative and it had to be passed. He rebutted each of these contentions and urged the members to contact their Congressmen expressing their views.

VII. New Offerings of the AAMC Management Advancement Program

Dr. Marjorie Wilson gave a brief update of the Management Advancement Program offerings describing the positive response of the seminars. They continue to offer Phase II and in alternate years the Financial Mangement Seminar.

VIII. Report of the President

Dr. Cooper, in his report, brought the Council up to date on manpower legislation since their previous discussion on Sunday. The Executive Committee in an earlier discussion decided the Association could not take a formal position favoring the one year extension of the current manpower bill, but should instead make known its desire for a bill that equals the level of appropriation of FY 1980. Dr. Cooper urged the deans to communicate with their Senators to encourage the sub-committee to provide the same level of authorization for FY 1981.

Dr. Kennedy then offered comments on the Budget Act. The budget sent by President Carter to the Congress proposed modest increases for research on the part of NIH with little in the area of health manpower legislation. There were slight increases proposed in National Health Service Corps scholarships, primary care programs, family medicine, general internal medicine, and general pediatrics, with a request for rescission of the 1980 capitation. A handout detailing the specifics of the budgetary cuts was distributed.

IX. Approval of Minutes

The minutes of the November 5, 1979 Annual Business Meeting held at the Washington Hilton Hotel were approved as submitted.

X. The National Board of Medical Examiners

Carmine Clemente, CAS Chairman who is a member of the NBME, introduced this topic to the Council. Regarding the NBME changes in governance, two actions were proposed at the recent meeting. First, the composition of the NBME was proposed to change so as to eliminate ex officio membership on the board of the Test Committee Chairmen in favor of nominating an equivalent number of members drawn at large from immediate past Test Committee Chairmen or committee members. The second governance change involved changing the name of the Executive Committee of the NBME to the Executive Board of the NBME and changing the composition and voting power of the membership in the proposed Executive Board.

The second item discussed by Dr. Clemente was the implementation of the Comprehensive Qualifying Examination. This has evolved over the past five years while the NBME considered replacing the traditional Board exam sequence, Parts I, II, and III, in favor of a qualifying exam to be given at the interface between undergraduate medical education and graduate medical education. A prototype of the exam was made available for inspection at the last NBME annual meeting. The consensus of the members, even after a cursory inspection, was that a major deficiency existed in the nature of the questions in the basic sciences with a need for additional developmental work on the prototype.

The third issue introduced by Dr. Clemente was the relationship between the CQE and Flex I. The Federation of State Licensing Boards is planning to develop a two-part licensing program which would consist of a Flex I exam, the passing of which would allow limited licensure in a supervised setting, a Flex II exam for full licensure given after two years of graduate medical education. The Flex I exam would most likely be the CQE. The intention of the Federation of State Medical Boards is that the adoption of Flex I and II would result in a phasing out of the National Board's certification program. Thus in the future the principal customer and source of revenue to the NBME would be the Federation of State Medical Boards.

The item was presented as an information item with no immediate action necessary by the Council of Deans. It was determined that AAMC representatives to the National Board continue to report to the involved components of the AAMC, keeping the Executive Council and Executive Committee abreast of any developments and that the Executive Committee set in motion some method where the COD may be proactive in the developments.

XI. Proposal for the Expansion and Improvement of Health Insurance in the United States

Dr. Gronvall presented this item to the Council by briefly describing the evolution of this paper. The AAMC's original position on national health insurance, contained in a document of several years ago, has been worked and reworked several times before arriving at this latest statement. This most recent revision contains suggestions from the deans at the November Business Meeting discussion. After a discussion by the COD, it will go to the Executive Council in June to be adopted as Association policy.

Dr. Gronvall summarized the three principal recommendations of the position statement: 1) that the Medicaid program be expanded and improved through a set of federal incentives that would broaden eligibility and standarize the scope of these benefits; 2) that there be strong incentives for the broadening of catastrophic health insurance purchased primarily by employers, but also the provision of insurance pools that could make available to other people catastrophic coverage; and 3) that a new independent commission be established that could review health insurance programs and put the "Good Housekeeping Seal of Approval" on them.

After some discussion, the Council agreed that this position statement was vastly improved over the former and offered minor suggestions for some modifications. The Council voted to adopt the statement with the understanding that the new statement would include suggested modifications.

XII. The AMA Section on Medical Schools

Dr. Dan Tosteson brought this before the Council on behalf of the group of medical school deans in Massachusetts. The AMA, since its inception, has been deeply interested in and concerned about matters relating to medical education. Its interest recently resulted in the establishment of the Section on Medical Schools which has sent to medical schools literature requests for involvement in this organization. The group of deans from Massachusetts has noticed an increasing overlap in the goals and intentions of the Section on Medical Schools of the AMA and the AAMC and has become confused as to how to interact with this Section. He inquired whether deans in other sections of the country shared their reaction and whether or not the Council should address the issue of trying to make sure that academic medicine is represented by a coherent and understandable voice in its participation in society at large.

Dr. Steve Beering, the first Chairman of the AMA Section on Medical Schools, provided some background as to his affiliation with this group. He assumed that leadership role to improve communication between the AAMC and AMA, to decrease disagreement on major issues in public, to provide an academic input at the grassroots level of the AMA by speaking directly in the AMA councils and delegations, avoiding public discord and achieving a consensus on issues important to both the AAMC and the AMA. Dr. Beering explained that the existence of this section, of which many deans are members, and the discussions which occurred had enabled members to avert several potential disasters on the floor of the House of Delegates.

Many members agreed that it was important to keep communications between the AMA and the AAMC open; participation in the Section on Medical Schools provides one way to accomplish this. Some members questioned the wisdom of the deans active and close participation in both the AMA Section on Medical Schools and the AAMC while others felt such participation benefited rather than hindered the growth of medical education.

XIII. The Impact of Proposals for Increased Competition to Contain Health Care Costs on the Teaching Hospital and Medical Education

Mr. John Colloton, Chairman of the Council of Teaching Hospitals, identified a new set of concerns relating to proposals which have cost containment as their objective. The shortcomings of the health care marketplace are cited as the cause for regulating the field. Even with the dramatic growth in regulation, however, policy makers remain concerned with the continuing escalation in health expenditures. In part as a product of the anti-regulation sentiment currently pervading the country and the Congress, there is a new emphasis on competition as a means of holding down costs.

In general, mechanisms for creating competition in the health field are being developed at two distinct levels. The first level would occur at the time the consumer obtains health insurance by giving the consumer the choice of options among health insurance plans or HMOs with high, low or intermediate benefits. Premium subsidy would be limited so that selection of a high cost plan would involve an out-of-pocket expense. It is theorized that individuals, in making their selection, will opt for lower cost plans at a lower premium cost and effect a change in the high technology style of medical practice now prevailing in this country.

The second level of competition would involve increasing consumer awareness at the time he or she obtains health services through the use of co-insurance and other out-of-pocket payments designed to make the consumer more cost conscious.

Several competitive plans are being espoused at the Congressional level with most embracing the following general principles: that the employee be given a fixed sum of dollars by income tax credit with which to choose among government-approved private health insurance plans or enroll in a health maintenance organization. Employees would have the choice to use the dollars made available to them for health care to purchase comprehensive coverage, catastrophic coverage only or an HMO type plan.

A plan embodying such principles would have the following characteristics: it would establish a health care economy made up predominantly of competing organized systems; government would determine the total dollars to be invested in health care by setting on a community-by-community rating basis the maximum tax allowance it would allow each citizen for purchase of a health plan; it would inject 150 million Americans into the medical marketplace, personally searching for and choosing various governmentally-approved health insurance plans or HMO packages; and controls on physician fees and hospital costs would be achieved by competition.

Testimony had recently been submitted on S. 1968, "The Health Incentives Reform Act." The final position taken was that no legislative action should be taken on this particular concept until such time as a series of critical issues relating to the survival and maintenance of teaching and research institutions are resolved. The AAMC Executive Council considered the matter at its March meeting and decided that an ad hoc committee with representatives of the three Councils be appointed to address the whole matter. The Council members offered some comments on Mr. Colloton's testimony to be passed on to the Executive Committee.

XIV. The LCGME: Its Development and Current Status

Dr. Richard Janeway discussed the Liaison Committee on Graduate Medical Education which originated in 1972. It was started, in part, because

at that time there was an emerging awareness that there needed to be some institutional responsibility for the graduate medical education process. The admirable effort to establish the LCGME to fulfill the functions they outlined contained one inherent flaw: all policy decisions would continue to be subject to approval by the parent organization. This has been a source of great travail. Nevertheless the Committee was established and some productive work has progressed. The LCGME has, for example, regularized and improved the documentation process used by RRC's to substantiate actions for approval or disapproval.

Recently, however, the American College of Surgeons has taken the position that an organization of Residency Review Committees should be created. This body would supervise RRC accreditation of residencies in surgery and its various specialties. The LCGME would act as an appeals body.

There was some discussion on whether or not the LCGME would continue to exist as a viable organization. Members felt it provided a needed function and thought every effort should be made to keep the LCGME a functional body.

XV. The LCCME: Its Development and Current Status

Dr. William Mayer presented this report to the Council by beginning with a brief history of the LCCME. The LCCME was voted to be created by the five parents in 1974 and in 1977 the LCCME took over the accreditation functions previously held by the AMA for the organizations and institutions that were carrying out CME in this country. In 1979 the Council on Medical Education, the Board of Trustees and the House of Delegates voted to withdraw from the LCCME. The position taken by the AMA at that time was that since they had withdrawn and since they were one of the parents of the LCCME the LCCME simply did not exist. They immediately followed with the establishment of their own accreditation system, with the development of the Committee on Accreditation of CME, CACME, as a review body reporting to the Council on Medical Education of the AMA as the accreditation body.

The result is two bodies, the existing LCCME, and now the current AMA, claiming that they are the accrediting body for organizations and institutions carrying out continuing medical education in this country.

There are several issues arising out of this conflict. First is the ownership and possession of records. In spite of the legal advice that those records belong to the LCCME, the AMA has refused to release them to the LCCME. But an arrangement has been made with the AMA that if the organizations and institutions who have been accredited will request that the AMA send a copy of their records to the LCCME, the AMA will do so. Dr. Mayer pointed out the name and address of the individual to whom to write requesting such records.

Dr. Mayer also urged the deans to work with their faculty and their specialty society links to solidify their relationship to the LCCME. The return of the AMA to the LCCME is an issue being worked on by several groups. Dr. Mayer emphasized that the LCCME was a very viable organization with no possibility that it may fold irrespective of any AMA action.

XVI. Invitational Meeting on Graduate Medical Education Task Force Report

Dr. Swanson announced that an invitational conference involving specialty boards, key government figures and other organizations and individuals interested in graduate medical education will be held in the fall for the purpose of discussing the Task Force Report on Graduate Medical Education. The format will be small group discussions in order to achieve individual input from the various invitees.

XVII. A Proposal for a Study of the General Professional Education of the Physician

Dr. Swanson referred to the proposal contained in the agenda book. The concept is to look at the general education of the physician as opposed to the specialized professional education of the physician. The strategy is to try to involve the total community concerned with medical education in a dialogue which would raise the level of interest and heighten the opportunity for the exchange of information and ideas. Dr. Swanson invited any comments to be passed on to him.

XVIII. New Business

Dr. Beering brought up the item of student participation in the LCME. He asked deans to nominate knowledgeable and appropriate students from which two representative members could be selected.

XVIX. Adjournment

The meeting adjourned at 12:00 noon.

ELECTION OF INSTITUTIONAL MEMBERS

The following medical schools have received full accreditation by the Liaison Committee on Medical Education and are eligible for Full Institutional Membership in the AAMC:

Uniformed Services University
of the Health Sciences
School of Medicine

University of Nevada
School of Medical Sciences

Wright State University
School of Medicine

The Executive Council has recommended, contingent upon approval by the full Council of Deans, Assembly election of the schools listed above to Full Institutional Membership in the AAMC.

RECOMMENDATION

That the Council of Deans approve the election of these schools to Full Institutional Membership.

ELECTION OF DISTINGUISHED SERVICE MEMBERS

At its June 26 meeting, the COD Administrative Board authorized the Chairman to appoint a small committee to solicit and screen recommendations from the membership for nominations for Distinguished Service Members. The committee, consisting of Drs. Luginbuhl and Mathies, met and presented its recommendations at the September 25 Board meeting. The following individuals were submitted for consideration for election to Distinguished Service Membership in the AAMC:

Theodore Cooper
William B. Deal
Frederick C. Robbins

The Executive Council has recommended, contingent upon approval by the full Council of Deans, Assembly election of these individuals to Distinguished Service Membership.

RECOMMENDATION

That the Council of Deans approve the election of these individuals as Distinguished Service Members.

REPORT OF THE NOMINATING COMMITTEE AND ELECTION OF OFFICERS

The Nominating Committee of the Council of Deans consisted of:

William B. Deal, Chairman
William F. Kellow
M. Roy Schwarz
Robert B. Uretz
W. Donald Weston

The committee solicited the membership for recommendations of persons to fill the available positions by memorandum dated March 21, 1980. The returned Advisory Ballots were tabulated and the results distributed to each committee member. The committee met by telephone conference call on June 24, 1980. Dr. Deal's letter report (dated July 1, 1980) of the committee's recommended slate of officers follows. Subsequent to that report, the committee held a second conference call meeting to recommend a person to fill the vacancy created by the resignation of Theodore Cooper, M.D. from the Board and Executive Council. The results of that meeting are included as an addendum to Dr. Deal's letter.

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WILLIAM B. DEAL, M.D.
Vice President for Health Affairs
KENNETH F. FINGER, PH.D.
Associate Vice President for Health Affairs

July 1, 1980

Stuart Bondurant, M.D., Dean
University of North Carolina
School of Medicine
Chapel Hill, NC 27514

Dear Stu:

This letter constitutes my report as Chairman of the Council of Deans' Nominating Committee to you as the Chairman of the Council of Deans. The committee met at 2:00 PM EDT on June 24, 1980 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
William H. Luginbuhl, M.D.
Dean
University of Vermont College of Medicine

Member-at-Large of the Council of Deans
David R. Challoner, M.D.
Dean
St. Louis University School of Medicine

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:

Council of Deans Representatives to the Executive Council
Edward J. Stemmler, M.D.
Dean
University of Pennsylvania School of Medicine

Richard H. Moy, M.D.
Dean and Provost
Southern Illinois University School of Medicine

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

Chairman-Elect of the Assembly
The nominating committee has authorized me, as chairman, to exercise my discretion in the deliberations of the AAMC nominating committee with the understanding that, all else being equal, I will support the nominee of the Council of Academic Societies.

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,

William B. Deal, M.D.
Vice President for Health Affairs
and Dean, College of Medicine

WBD/hb

cc: William F. Kellow, M.D.
M. Roy Schwarz, M.D.
Robert B. Uretz, Ph.D.
W. Donald Weston, M.D.
Joseph A. Keyes

THE COMMITTEE MET AGAIN ON THURSDAY, SEPTEMBER 11, TO RECOMMEND A PERSON TO FILL THE VACANCY CREATED BY THE RESIGNATION OF THEODORE COOPER, M.D. FROM THE BOARD AND THE EXECUTIVE COUNCIL. THE COMMITTEE SELECTED:

John W. Eckstein, M.D.
Dean
University of Iowa
College of Medicine

A COMPARATIVE ANALYSIS OF SELECTED HEALTH MANPOWER PROPOSALS

September 1980

INSTITUTIONAL SUPPORT

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
xpires September 30, 1980	As approved by Senate Committee on Labor & Human Resources 6/27/80.	As approved by House Interstate and Foreign Commerce Committee 5/7/80.
apitation Grants	Capitation Grants	Capitation Grants
) P.L. 94-484 continued the capitation grant program which provides flexible institutional support to medical schools through FY 1980 on the condition that medical schools in the aggregate and individually meet certain conditions. The conditions for participation in the capitation grant program are: a) Maintenance of first year enrollment. b) Maintenance of level of non-Federal expenditures. c) Medical schools must have 40%, 45% & 50% of filled first year residency positions in direct or affiliated residency training programs in primary care for FY 78, 79, & 80 respectively. Unless requirement is met by a national average of all schools on July 15, before a fiscal year begins, schools individually must meet requirements on July 15 of the following year. d) Schools must increase third year enrollment for 1978-79 by 5%. Enrollment increase designed for USFMS students. U.S. students excluded by statute from enrollment increases.	1) Repeals Capitation Grant Program and replaces it with National Incentive Priority Grant Program. 2) National Incentive Priority Grant would provide $250 per student to the institution for FY 82, 83, & 84 for each of the objectives that are met by the school in the year the grant application is made. The objectives included in the bill are the following: a) The school conducts, or will conduct within 12 months, 10% or more of its undergraduate clinical education in areas in which medically underserved populations reside or in ambulatory, primary care settings geographically remote from the main site of the teaching facilities of the school. b) All fourth year students have had, or will have had before graduation, a significant educational experience in at least two of the following areas: nutrition, geriatrics, rehabilitation, health care economics & health policy or occupational & environmental health c) Sixty-five percent of the school's filled first year positions in direct or affiliated approved residency training programs, are in general internal medicine, general pediatrics or family practice; or	1) Continues Capitation Grant Program with conditions very similar to PL 94-484 but phases it out at end of FY 83. a) Maintenance of level of non-Federal expenditures. b) Medical Schools must have 50% of filled first year residency positions in direct or affiliated residency training programs in primary care for FY 81, 82, & 83, respectively, after the number of individuals who transferred out of primary care after the first year of training is deducted. Unless requirement is met by a national average of all schools on July 15, before a fiscal year begins, schools individually must meet requirements on July 15 of the following year.

INSTITUTIONAL SUPPORT

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
	Twenty percent or more of the school's graduating students enter approved family practice residencies. d) The school, either itself or in cooperation with other entities, conducts or will conduct within 12 months, a substantial community program of preventive health services (including health promotion and health information) designed to reduce the risk factors of the leading causes of death or morbidity in the community (including the risk factors among special population groups such as prisoners or institutionalized children) and in which students of the school receive substantial education in preventive and community medicine. e) Twenty percent of the graduating class will have had substantial educational experience that will lead to careers in clinical investigation and research. f) The enrollment of underrepresented minority groups in the first year class will be 12% for FY 82, 15% for FY 83 and 18% for FY 84. 3) In computing the enrollment of the institution, all institutions would double the number of minority students.	

INSTITUTIONAL SUPPORT

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
Authorization Levels	Authorization Levels	Authorization Levels
FY 1978 $125 million	FY 1982 $37 million	FY 1981 $37 million
FY 1979 $132 million	FY 1983 $40.7 million	FY 1982 $24 million
FY 1980 $130 million	FY 1984 $44.5 million	FY 1983 $12 million

SPECIAL PROJECTS

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
unding	Funding	Funding
) Reimburses the school for the cost of the project.	1) Reimburses the school for the cost of the project.	1) Reimburses the school for the cost of the project.
isting of Special Projects	Listing of Special Projects (Projects with an * asterick available to chiropractics).	Listing of Special Projects
) Department of Family Medicine Establishment of Departments of Family Medicine FY 80 Authorization $20,000,000 a) Family Medicine and General Practice of Dentistry FY 80 Authorization $50,000,000	1) Department of Family Medicine Project Grants for Family Medicine FY 82 Authorization $9 million a) Family Medicine and General Practice of Dentistry Family medicine component included in above authority.	1) Department of Family Medicine Projects Grants for Department of Family Medicine FY 81 Authorization $15,000,000
) AHECS FY 80 Authorization $40,000,000	2) AHECS Area Health Education Centers FY 82 Authorization $21 million	2) AHECS Areas Health Education Centers FY 81 Authorization $21,000,000
) Education of USFMS Students Education of returning U.S. students from foreign medical schools. FY 80 Authorization $4,000,000	3) Education of USFMS Students Not addressed.	3) Education of USFMS Students Not addressed.
) PA's and EFDA's Programs for PA's Expanded Function Dental Auxiliaries (EFDA) and Dental Team Practice FY 80 Authorization $35,000,000	4) * PA's and EFDA's Programs for PA's, Expanded Function Dental Auxiliaries and Chiropractics FY 82 Authorization $16 million	4) PA's and EFDA's Physician Assistants and Dental Auxiliaries FY 81 Authorization $14,000,000
) Training in General Medicine and Pediatrics Grants for training in general internal medicine and general pediatrics (not available to hospitals).	5) * Training in General Medicine and Pediatrics Training in primary care internal medi- and pediatrics available to schools schools and hospitals.	5) Training in General Medicine and Pediatrics Grants for training in general internal medicine and pediatrics available to schools and hospitals.

SPECIAL PROJECTS

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
FY 80 Authorization $25,000,000	FY 82 Authorization $17 million	FY 81 Authorization $23,000,000
6) Educational Assistance to Disadvantaged FY 80 Authorization $20,000,000	6) Educational Assistance to Disadvantaged FY 82 Authorization $22 million	6) Educational Assistance to Disadvantaged FY 81 Authorization $25,000,000
7) Projects in Preventive Medicine or Dentistry Not in current law.	7) Projects in Preventive Medicine or Dentistry Projects for the establishment of departments or residency training programs. FY 82 Authorization $5 million	7) Projects in Preventive Medicine or Dentistry Projects in Preventive Medicine or Dentistry for establishment of departments or residency training programs. FY 81 Authorization $8,000,000
8) Miscellaneous Projects Incorporated in list of 21 special projects in Sec. 788d.	8) Miscellaneous Projects *a) Remote site training and support services in underserved areas. *b) Educational curriculum and program development. c) Projects to reduce the total cost of health professions education. *d) Projects for women in health. e) Grants for training in PM & R. f) Special projects for physicians in graduate training.	8) Miscellaneous Projects (Included in Financial Distress authority below.)
9) Start-Up Assistance Financial Distress Interdisciplinary training and Curriculum Development FY 80 Authorization $25,000,000	9) Financial Distress Grants Two kinds of Financial Distress Grants: a) Similar to existing law but available for maximum of 3 years; can be used for operating costs, accreditation & carrying out operational, financial, and managerial reforms.	9) Start-Up, Financial Distress, Interdisciplinary Training and Curriculum Grants FY 81 Authorization $29,000,000

SPECIAL PROJECTS

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
	FY 82 Authorization $3 million b) Advanced grant available up to five years. School must have an approved plan to achieve solvency within five years. FY 82 authorization $9 million	
0) Start-Up Assistance Incorporated in Financial Distress.	10) Start-Up Assistance There are no start-up assistance grants for medical schools.	10) Start-Up Assistance Incorporated in previous section.

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
1. HEAL Program	1. HEAL Program	1. HEAL Program
Eligibility. MODVOPP and public health students.	Eligibility. MODVOPP, chiropractic, public health, physician assistant or expanded function dental auxiliary training programs, graduate program of health administration, and clinical psychology and advanced nurse training students.	Eligibility. Same as in current law.
Restrictions on Eligibility. Students may not hold GSL loan in same academic year. No more than 50% of each school's students can receive HEAL loans.	Restrictions on Eligibility. None.	Restrictions on Eligibility. None.
Limits. Aggregate of $60,000 for medical students.	Limits. Aggregate of $80,000 for medical students.	Limits. Aggregate of $80,000 for medical students.
Interest Rate. Maximum rate of 12% plus 2% annual insurance premium.	Interest Rate. Current bond equivalent of 91 day T-bill plus 2.5% and 2% annual insurance premium.	Interest Rate. Current bond equivalent of 91-day T-bills plus 2% plus 2% annual insurance premium.
Deferment. Repayment on principal deferred during medical school and 3 years of: internship or residency; service in Armed Forces, Peace Corps or NHSC. Interest must be paid during these periods.	Deferment. Repayment on principal and interest deferred during: medical school and 4 years of service in Armed Forces, Peace Corps or NHSC; or 5 years of internship or residency.	Deferment. Repayment on principal and interest deferred during medical school and 4 years of internship, residency; and, 3 years of service in NHSC, Peace Corps, or Armed Forces.

STUDENT ASSISTANCE

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
Repayment. 10-15 years beginning 9-12 months after graduation.	Repayment. 10-15 years beginning 9-12 months after graduation. Provides for less burdensome repayment terms by requiring that borrowers be offered: 1) graduated repayment option with larger payments due later; and 2) a variable interest option to be offered at the option of the lender.	Repayment. 10-15 years beginning 9-12 months after graduation. Provides for less burdensome repayment requirements by requiring that the borrower be offered a schedule for repayment under which a portion of the payment is due later in the repayment period.
Overall Loan Limits. Current law authorized that total principal amount of HEAL loans that could be Federally guaranteed could not exceed $520 million for FY 80.	Overall Loan Limits. Total principal amount of HEAL loans that could be Federally guaranteed could not exceed: $100 million for FY 82; $120 million for FY 83; and, $140 million for FY 84.	Overall Loan Limits. Total principal amount of HEAL loans that could be Federally guaranteed could not exceed $520 million for each of FY 81-83.
Allowable Expenditures. Tuition & fees.	Allowable Expenditures. Tuition, fees, and reasonable living expenses.	Allowable Expenditures. Same as in current law.
Loan Forgiveness. Forgiveness of $10,000/year permitted at the discretion of the Secretary in return for a minimum of 2 years service in NHSC or in private practice in shortage areas. Loan totally discharged in cases of death or permanent disability.	Loan Forgiveness. Partial forgiveness of principal and interest in return for minimum of 2 yrs. service in NHSC or in shortage areas: 10% or $6,000, whichever is greater, for the first or second year of service; & 15% or $9,000, whichever is greater for the third or fourth year of service. Amount of debt that can be paid in this fasion is 50% of principal of each loan. Loan also discharged in cases of: death, permanent disability failed first year who are unsuccessful in retaking first year courses; students from disadvantaged families meeting certain income levels; those not expected to resume training within 2 yrs; and, to permit failed first year students to retake courses if they are not successful in this attempt. These provisions apply to all loans used to finance health professions education.	Loan Forgiveness. Same as in current law.

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
2. HPSL Program. Program funded by revolving fund using Federal and school funds. (9/1 ratio). After FY 1983, pursuant to individual agreements between the schools and the Secretary, each school shall begin returning these funds to the Federal government.	2. HPSL Program. Phased out. Schools are authorized to make loans in FY 82 to previous HPSL recipients who are enrolled in the last-year of study. Such loans will be made out of HPSL Revolving Fund. Requires that the Federal government begin to recover HPSL funds from the schools after FY 82. Federal government capital and income from the dissolution of this program be utilized to help finance new Service Contingent Loan Program set up by the Bill to replace HPSL.	2. HPSL Program. Reauthorized as in current law. Extends until FY 1986, the requirement in P.L. 94-484, that the Federal government begin to recover HPSL capital funds from the schools.
Authorization. $28 million FY 81; $16.5 million appropriated.	3. Service-Contingent Loan Program Authorization. To help finance loan fund: $13 million, FY 82; $20 million, FY 83; $40 million, FY 84. If needed 25% of these funds allocated to nursing students. Also, authorizes the appropriation of such sums as the Secretary might request to meet insufficiencies of the fund for certain purposes such as discharge of loans upon death or disability or borrower.	Authorization. $20 million, FY 81; $22.5 million, FY 82; $25 million, FY 83.

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
Eligibility. MODVOPP students. Medical students graduating after 5/30/ 80 must be in exception financial need (resources equally less than $5,000 or half the cost of attending school, whichever is less.)	Eligibility. MODVOPP public health, nursing, graduate programs in health administration and programs for training of physicians assistants expanded dental auxiliaries, nursing anesthetists. Students must be in need of the amount of the loan. Need to be determined by the school. Students may not receive NHSC, IHS, Armed Forces, State-Service Scholarships in same academic year.	Eligibility. Same as in current law.
Limits. Tuition plus $2500/year. No aggregate limit.	Limits. Aggregate of $80,000 for medical students.	Limits. Same as in current law.
Interest Rate. Completely subsidized during school. 7%, one year after graduation.	Interest Rate. Subsidized interest rate of the lesser of 7% or $\frac{\text{T bill}}{2} + 1.5\%$ during: medical school; first year of graduate training; service in a shortage area, Armed Forces, or for a Federal, State or local government entity; full-time teaching in a higher education institution; research on more than a half-time basis as part of full time position in health professions shcool, non-profit or Federal biomedical research facility; training or serving as a public health professional; internship, residency or practice in general or family practice, general internal medicine, pediatrics, preventive medicine, psychiatry, or rehabilitative medicine; and 3-5 years of advanced research training or 3 yrs. of a doctoral program leading to a career in biomedical or clinical investigation or academic health professions career.	Interest Rate. Same as in current law.

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
	After these periods medical students would be charged interest at the rate of T bill + 1.5%. The T-Bill is determined at the time the student initially secured the loan.	
Deferment. Repayment deferred for up 3 yrs. for Armed Forces, Peace Corps, NHSC, and up to 5 yrs. for further advanced professional training.	Deferment. Repayment of both principal and interest deferred (interested accrues and compounds) during service in: national priority position; 4 yrs. in NHSC, IHS, Armed Forces, Peace Corps; 5 yrs. internship or residency; 3 yrs. advanced research training; 3-5 yrs. (to be determined by the Secretary) in doctoral program leading to a career in a biomedical or clinical investigation, or academic career in a health profession.	Deferment. Same as in current law.
Repayment. Ten years beginning one year after graduation.	Repayment. Fifteen years beginning one year after graduation.	Repayment. Same as in current law.
Service Commitment. None.	Service Commitment. Requires commitment of all borrowers to serve in national priority positions. The number who are called to service in return for laon discharge are controlled by Congressional appropriations.	Service Commitment. None.
Loan Forgiveness. Secretary forgives 60% of the debt in exchange for 2 yrs of service in a designated shortage area and an additional 25% for a third yr. of service.	Loan Forgiveness. Same conditions as those outlined under the HEAL Program but also includes provisions providing for a waiver or deferral of service obligations or monetary penalties in cases where fulfillment of the service obligation would be unconscionable, impossible, involve	Loan Forgiveness. Same as in current law.

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
	extreme hardship the student fails to maintain acceptable academic standing, or the studnet is dismissed for disciplinary reasons.	
3. Scholarship Program for First-Year Students in Exceptional Financial Need (EFN)	3. Scholarship Programs for First-Year Students in Exceptional Financial Need (EFN)	3. Scholarship Programs for First-Year Students in Exceptional Financial Need (EFN)
Eligibility. First-year MODVOPP students in exceptional financial need---those with virtually no resources.	Eligibility. Same as in current law.	Eligibility. First and second year MODVOPP students in exceptional financial need---those with virtually no resources.
Limits. Tuition, fees and a living stipend of approximately $5500/year.	Limits. Lesser of tuition and fees plus $2500 or $5000.	Limits. Same as in current law.
Allocation of Awards. To all health professions schools with priority to MOD schools.	Allocation of Awards. Each health professions school will receive 2 scholarships. The remainder will be distributed to MOD schools based on proportionate enrollment of first yr. students in exceptional financial need.	Allocation of Awards. Priority to MOD schools.
Authorizations. $16 million FY 78; $17 million FY 79; and $18 million FY 80. (only $10 million actually appropriated in FY 80).	Authorizations. $15 million FY 82; $16 million FY 83; and, $17 million FY84.	Authorizations. $30 million FY 81; $40 million FY 82; and, $50 million FY 83.

NATIONAL HEALTH SERVICE CORPS PROGRAM

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
1. NHSC Programs.	1. NHSC Programs.	1. NHSC Programs.
Categories of Service.	Categories of Service.	Categories of Service.
a) Officers of the Regular and Reserve Corps of the Service.	Same as in current law.	a) Officers of the Regular and Reserve Corps of the Service.
b) Designated civilian personnel.		b) Appointed U.S. civilian personnel.
		c) Non-U.S. civilian personnel.
Designation of Shortage Areas.	Designation of Shortage Areas.	Designation of Shortage Areas.
Urban or rural areas in which the Secretary determines shortage exists; population groups or public or non-profit private medical facility or other public facility deemed to have such a shortage.	Same as in current law but also permits certain hospitals to be designated as such in order to reduce dependency on alien foreign medical graduates.	Same as in current law but requires HSAS & SHPDAS to approve or disapprove the designation. Also, requires the Secretary to undertake an evaluation of the criteria utilized to designate these areas.
Assignment of Corps Personnel.	Assignment of Corps Personnel.	Assignment of Corps Personnel.
To public or nonprofit entities located in shortage areas.	Same as in current law but specifies that in assigning personnel to a State, the Secretary must first assign those who have taken their training in that particular state.	Same as in current law but specifies that non-U.S. employees assigned to those entities must be assured by the entity a salary and employment benefits equal to that of Corps members who are serving as U.S. civilian employees. If the entity does not have sufficient funds, the Secretary may make a grant for this purpose. Also, in order to improve the assignment of Corps members, it provides for coordination with the States and other public and non-profit entities to establish programs

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
		Assignment of Corps Personnel. for the planning, development and operations of centers for the delivery of primary health care in shortage areas. Establishes an NHSC Fund to carry out these purposes.
Authorizations. $70 million FY 80; $70 million appropriated.	Authorizations. Expectation that it will be reauthorized in FY 81 Continuing Resolution.	Authorizations. $94 million FY 81; $145 million FY 82; and, $205 million FY 83.
New Programs. Not applicable.	New Programs. Requires Secretary to conduct or support preparatory programs for NHSC Scholarship recipients.	New Programs. Permits Secretary to make grants for the conduct of preparatory programs for NHSC Scholarship recipients.
2. NHSC Scholarship Program	2. NHSC Scholarship Program	2. NHSC Scholarship Program
Authorizations. $200 million FY 80; $85.5 million was appropriated.	Authorizations. $55 million; FY 82 $48 million; FY 83 $48 million; FY 84	Authorizations. $92.0 million FY 81; $101 million FY 82; $109 million, FY 83.
Allocation of Appropriations. 90% of sums appropriated will set aside for MOD students; 10% of this must go to dental students.	Allocation of Appropriations. Same as in current law.	Allocation of Appropriations. Same as in current law.

NATIONAL HEALTH SERVICE CORPS PROGRAM

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
Selection Priorities. 1) Previous NHSC or EFN Scholarship recipients. 2) First-year students.	Selection Priorities. 1) Previous NHSC Scholarship recipients. 2) Previous EFN Scholarship recipients. 3) All other eligible individuals. Priority within these categories will be given to those individuals who agree to provide medical services to Indians through IHS.	Selection Priorities. 1) Previous NHSC or EFN Scholarship recipients. 2) First-year students---in determining priorities the Secretary must give special consideration to individuals who: intend to be primary care physicians in shortage areas; have resided or been employed in such areas; or, who meet other qualifications to assist in determining if the individual will become a primary care physician in such an area.
Apportionment of Awards to the States. Nothing specified.	Apportionment of Awards to the States. States participating in State-Service Scholarship Program cannot receive more than 10% of funds appropriated for the NHSC Scholarship Program.	Apportionment of Awards to the States. Nothing specified.
Scholarship Recipients and National Research Service Awards. Permits Scholarship recipients with "exceptional promise for medical research" to perform their service obligation under NRSA Program at the Secretary's discretion.	Scholarship Recipients and National Research Service Awards. Same as in current law.	Scholarship Recipients and National Research Service Awards. Mandates that service under the NRSA Program be counted against obligated service for NHSC Scholarship recipients.

NATIONAL HEALTH SERVICE CORPS PROGRAM

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
3. NHSC Private Practice Option Secretary is required to release NHSC Scholarship recipient from service obligation in return for service in private practice in a shortage area.	3. NHSC Private Practice Option Same as in current law but renames it "Independent Practice".	3. NHSC Private Practice Option Same as in current law.
Income Equivalence Test Shortage area must have sufficient financial base to provide individual with income equal to that of Corps members.	Income Equivalence Test None.	Income Equivalence Test None.
Technical Assistance None.	Technical Assistance Requires Secretary to provide such individuals with technical assistance by paying: $10,000 in 1st year; $7500 in 2nd year; $5000 in 3rd year; and, $2500 in 4th year; or the difference between the individuals income and that of a Corps member, whichever is less, plus the cost of the individuals malpractice insurance.	Technical Assistance Secretary must, upon request, provide technical assistance to such individuals to assist them in the establishment of their practice.
Assignment of Medicare/Medicaid Patients Requires that physicians under this option not discriminate against Medicare/Medicaid patients in providing health services.	Assignment of Medicare/Medicaid Patients Requires that physicians under this option accept Medicare/Medicaid patients on assignment.	Assignment of Medicare/Medicaid Patients Requires that physicians under this option accept Medicare/Medicaid patients on assignment.

NATIONAL HEALTH SERVICE CORPS PROGRAM

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
4. New NHSC Modelled Programs Not Applicable.	4. New NHSC Modelled Programs Establishes a new State-Service-Conditional Scholarship Program modelled on the NHSC to off-set phase down of the NHSC Scholarship Program which would: • Establish a program of matching grants (6/1) to the States to fund scholarships to students willing to serve in shortage areas. • Require States to assume responsibility for assuring a minimum salary. • Permit individuals to enter private practice in shortage areas in lieu of payback through State service. • Not permit previous NHSC Scholarship recipients to be eligible for this program. Authorizations: $6 million for FY 82; $13.5 million; and $15 million for FY 83.	4. New NHSC Modelled Programs None.

CONSTRUCTION

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203 & H.R. 7204)
) Enrollment Requirements Requires the first year enrollment the year following the completion of the construction and for the next nine years to exceed the highest first year enrollment for any of the five preceeding school years by at least 5% or five students whichever is greater.	1) Enrollment Requirements Unilaterally repeals enrollment increase requirement under construction grant authority.	1) Enrollment Requirements Repeals enrollment increase.
') Construction Grants Provides the Secretary with Construction Grant authority to assist in the construction of teaching facilities for the training of health professionals. FY 80 Authorization $40,000,000	2) Construction Grants Provides funds for renovation, modernization and conversion of existing facilities. FY 82 Authorization $1 million	2) Construction Grants Repeals authority.
') Loan Guarantees and Interest Subsidies Provides loan guarantees and interest subsidies for construction of teaching facilities. FY 80 Authorization $3,000,000	3) Loan Guarantees and Interest Subsidies Continues the authority for loan guarantees and interest subsidies but requires the subsidy to be either 6% lower than market rates or no higher than 7% whichever is less. The combined total of the principal of the loan guarantee and the principal of the interest subsidy for any entity must not exceed $10,000,000 for any fiscal year. FY 82 Authorization $5 million	3) Loan Guarantees and Interest Subsidies Provides loan guarantees and interest subsidies for renovation projects. No authorization noted.

AMENDMENTS TO THE IMMIGRATION AND NATIONALITY ACT

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
) J-Visa Training Period Training period permitted under J-Visa is two years plus a possible extension for a third year.	1) J-Visa Training Period Extends period of training under J-Visa to the lesser of 7 years or period of time necessary to complete a training program as determined by the Director of the International Communications Agency for any alien acquiring exchange visitor status after January 10, 1978. An alien may change the designated program not more than once within two years time.	Not addressed.
) VQE Waiver Period Extends VQE waiver period through December 31, 1980.	2) VQE Waiver Period Extends VQE waiver period through December 31, 1985, but places limits on the number of aliens who may obtain J-Visas under the exemption. a) Total number of aliens at any one time may not exceed number participating in such programs on Jan. 10, 1978. b) For 1981 and 1982, number of waivers for a program cannot exceed number that entered U.S. under such an exemption to participate in that program in 1980. c) For 1983, number cannot exceed 75% of total number given in 1980. d) For 1984, the number cannot exceed 50% of the number in 1980. e) For 1985, the number cannot exceed 25% of the total in 1980.	Not addressed.

AMENDMENTS TO THE IMMIGRATION AND NATIONALITY ACT

Current Law	Kennedy/Schweiker Bill (S.2375)	Waxman Bill (H.R. 7203)
3) VQE Exemption Exempts from VQE alien FMG's with Board Certification and licensed to and in practice in a state prior to January 9, 1977.	3) VQE Exemption Same as current law.	Not addressed.
4) Designation of Health Manpower Shortage Areas Does not designate hospitals with a dependence on FMG's as Health Manpower Shortage Areas.	4) Designation of Health Manpower Shortage Areas Designates public and private hospitals with accredited residency training programs as health manpower shortage areas if the hospital serves a medically underserved population as defined in current PHS law; provides one or more accredited GME programs; one or more aliens have participated prior to December 31, 1980 in a GME program pursuant to a waiver; and it will reduce the hospital's reliance on FMG's. These hospitals will be given high priority for purpose of placement of Corps physicians. This provision expires December 31, 1985.	Not addressed.

ACCREDITATION COMMITTEES REORGANIZED

From their inception in 1972, the Coordinating Council on Medical Education, the Liaison Committee on Graduate Medical Education and the Liaison Committee on Continuing Medical Eduation have been plagued by conflict and controversy. In 1979, the AMA withdrew from the LCGME and established a separate accrediting committee for continuing medical education. In 1980, the American College of Surgeons threatened to establish a separate system for the accreditation of programs in surgical specialities unless changes were made in the LCGME and its functions. These events were merely reflective of the long-standing difficulties the sponsoring organizations of the two liaison committees have had in reaching agreements on policies and operating principles.

In September, after a series of conferences among the senior elected officers and chief executive officers of the ABMS, AMA, AHA, AAMC and CMSS, the five organizations announced plans to reorganize the accreditation system. The old organization and relationships are shown in Figure 1; the new organization relationships are shown in Figure 2.

The Coordinating Council on Medical Education has been abolished. In its place the Council for Medical Affairs has been established with representation by the two top elected officers and the chief executive officers of each organization. The CFMA will provide a forum for discussion of medical education issues and other matters of mutual concern to the organizations. The CFMA will not have a direct role in accreditation.

The Liaison Committee on Medical Education will continue unchanged in sponsorship, representation and function.

The LCGME will be replaced by an Accrediting Council on Graduate Medical Education (ACGME). The ACGME will have the representation shown in Figure 2. Staff services will be provided by the American Medical Association under the conditions of a letter of agreement. Revenues to pay for the cost of accreditation will be generated by charges to programs. This will probably be a combination of an annual charge based on the number of positions in a program and an additional charge for periodic review and accreditation. The ACGME sponsors will pay for the cost of ACGME meetings and policy development activities.

The ACGME will have the authority to accredit graduate medical education programs which have been recommended for accreditation by residency review committees. It will establish policies and procedures for residency program accreditation. Residency review committees may continue to forward their accreditation recommendations to the ACGME or a RRC may request that the authority to accredit be delegated to it. The ACGME may grant such authority on a time limited basis, subject to monitoring and periodic review. Program directors will be informed of residency review committee recommendations or accreditation decisions after each residency review committee meeting. This will eliminate the delays caused by waiting until the LCGME takes action. Such delays have been a constant source of irritation and frustration.

The ACGME will be responsible for the General Requirements section of the Essentials of Accredited Residencies. Changes in the general requirements must be unanimously approved by the five sponsors. Residency review committees will be responsible for the special requirements subject to review of their sponsoring organizations. The ACGME will approve all special requirements.

The structure and functions documents establishing the operations of residency review committees will be developed by the residency review committees within guidelines established by the ACGME and will be subject to approval by the ACGME. The ACGME will be responsible for the procedures for appealing adverse accreditation decisions.

Only specified items will require unanimous approval by the sponsoring organizations. The General Requirements of Accredited Residencies and the bylaws must be ratified by all sponsors. Action within 180 days of receipt is required. A sponsor failing to act within that time will be considered to have given approval. Fiscal policies (including fees, service charges, member assessments, grant applications and the annual budget) and authorizations of new programs and activities must be approved by two-thirds of the members of the ACGME present and voting. Any sponsoring organization may request within 45 days of the vote the submission of any item so approved to all sponsoring organizations. Each sponsoring organization then must approve before the item becomes effective. A sponsoring organization must act within 90 days of receipt of such an item or it shall be deemed to have approved it.

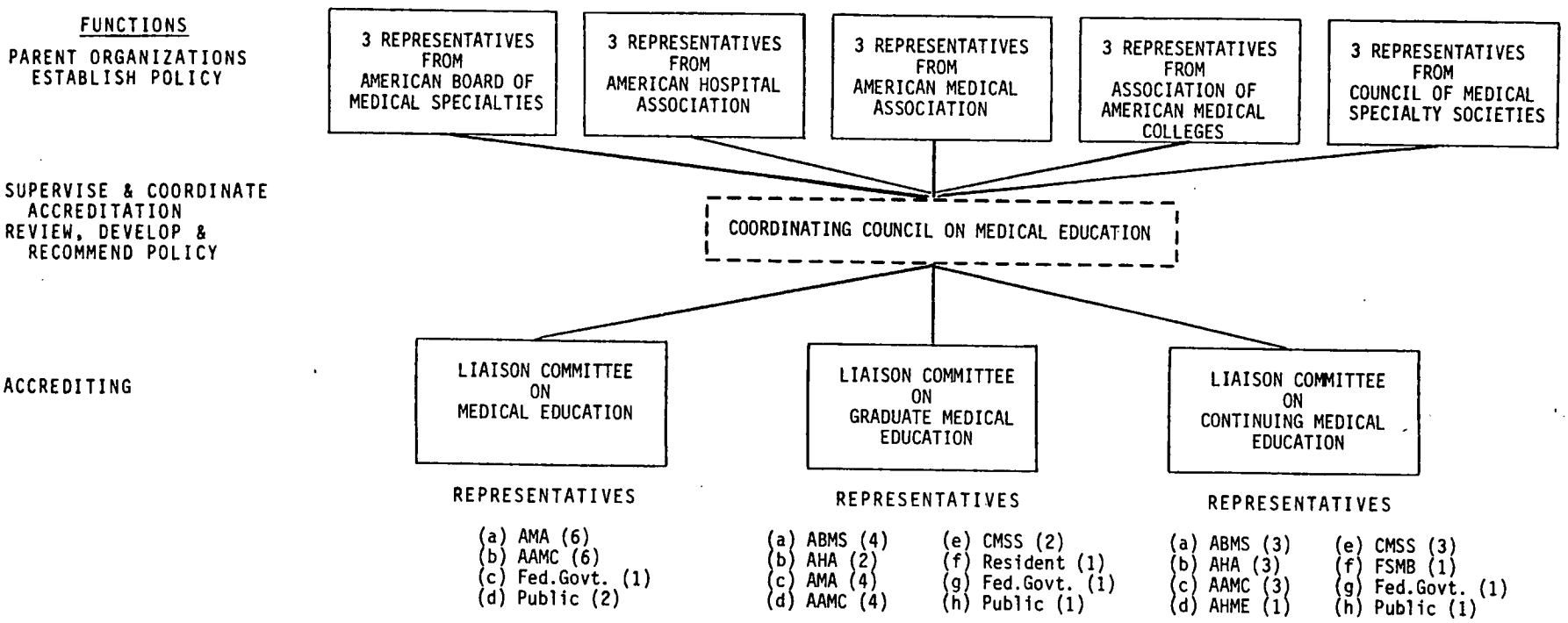
The Liaison Committee on Continuing Medical Education will be replaced by an Accrediting Council on Continuing Medical Education. Representation on the Council will be as shown in Figure 2. Staff services for the ACCME will be provided by the Council of Medical Speciality Societies under the conditions of a letter of agreement. Revenue to pay for the cost of accreditation will be generated by charges to organizations sponsoring CME programs. The ACCME sponsors will pay for the expenses of meetings and policy development activities.

Intrastate continuing medical education programs will be accredited by state associations or consortia under standards developed by the ACCME. The ACCME will be the accrediting authority for interstate and medical school sponsored programs. The items subject to unanimous approval by the sponsors will be the same as for the ACGME.

This reorganization and agreement on policies and procedural matters was achieved in an atmosphere of cooperation and mutual concern for improving the accreditation of medical education.

Figure 1

RELATIONSHIPS AMONG PARENT ORGANIZATIONS, COORDINATING COUNCIL ON MEDICAL EDUCATION, AND LIAISON COMMITTEES
1980

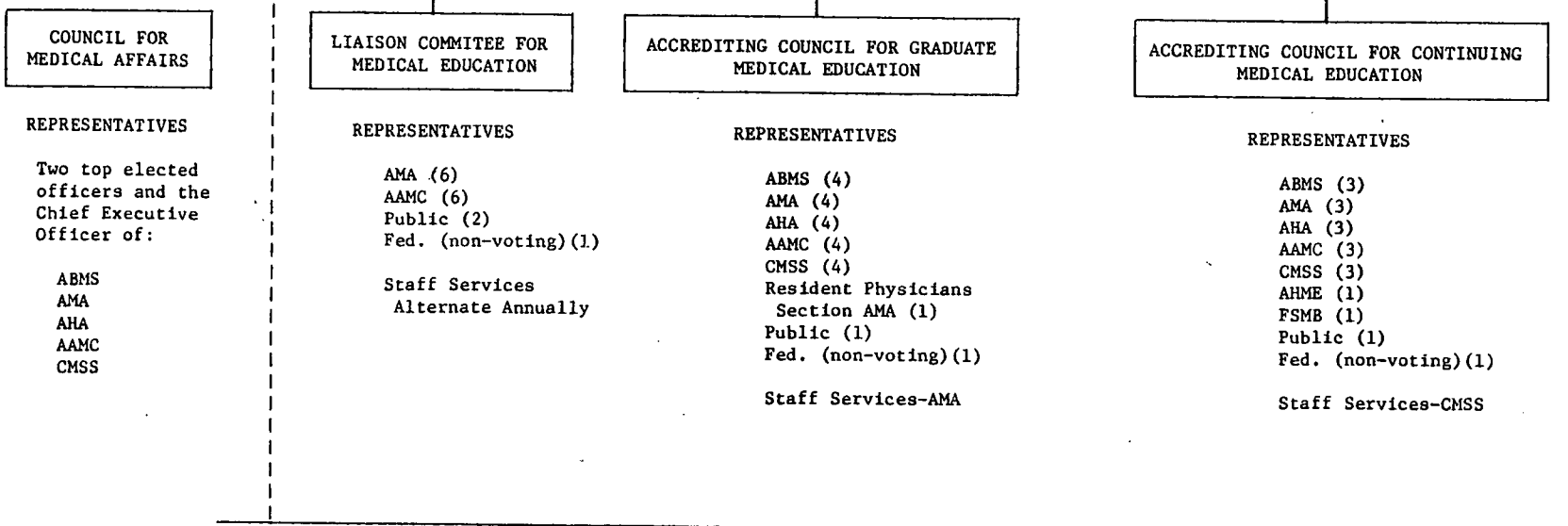


AMA	American Medical Association	AHA	American Hospital Association	AHME	Association of Hospital Medical Education
AAMC	Association of American Medical Colleges	CMSS	Council of Medical Specialty Societies	FSMB	Federation of State Medical Boards
ABMS	American Board of Medical Specialties				

SOURCE: American Board of Medical Specialties. Annual Report, 1978-1979. Evanston, Illinois: American Board of Medical Specialties, 1979. (Revised 1/1980, Association of American Medical Colleges).

Figure 2

ACCREDITATION BODIES FOR MEDICAL EDUCATION



ABMS - American Board of Medical Specialities
AMA - American Medical Association
AHA - American Hospital Association
AAMC - Association of American Medical Colleges
CMSS - Council of Medical Speciality Societies
AHME - Association of Hospital Medical Educators
FSMB - Federation of State Medical Boards

MEDICAL SCIENCES KNOWLEDGE PROFILE PROGRAM

The AAMC in cooperation with the National Board of Medical Examiners administered the first Medical Sciences Knowledge Profile Examination (MSKP) June 10-11, 1980. This examination was developed to assist AAMC member schools in determining levels of attainment in the sciences basic to medicine for individuals being considered for placement with advanced standing.

Two-thousand one hundred and forty-four (2,144) registrations were processed for the 1980 MSKP examination. This compares with 2,425 who were sponsored under the COTRANS program of the previous year. Of the 2,144 registrants, 1,794 actually sat for the MSKP examination; the previous year, a total of 1,985 candidates were administered Part I of the Boards on the June and September dates. Scores were reported on a scale of 1 (lowest) to 9 (highest) for each of the following areas: Anatomy, Behavioral Sciences, Biochemistry, Introductory Clinical Diagnosis, Microbiology, Pathology, Pharmacology and Physiology. Examinees and medical school admissions officers were provided with information to assist in the interpretation of MSKP score results. This information provided the opportunity to compare an individual's performance with all other MSKP examinees and also with the predicted performance of a sample of students from U.S. medical schools. The U.S. student group was comprised of approximately 1,000 second year students from six U.S. medical schools.

The development of these norms also made it possible to compare the performance of that group of MSKP examinees most similar in stage of education to U.S. students. The performance of this subset of MSKP examinees (N=1,300) generally fell at the seventeenth percentile of the U.S. student population on most of the eight scales of the exam. Three notable exceptions were the Introduction to Clinical Diagnosis, Behavioral Sciences, and Physiology measures. These fell in the eight to tenth percentile range.

A separate analysis was made of that group of examinees who were enrolled at the ten foreign schools supplying the largest number of examinees. This group accounted for 961 or about 74% of the subset of 1,300. It is noteworthy that the schools comprising this subset were mainly those established for the express purpose of attracting U.S. citizens unable to gain acceptance in an LCME accredited school. The general pattern of performance of the students from this group of schools was almost indistinguishable from the 1,300 in terms of their relationship to the performance of U.S. students.

The MSKP program will be continued during 1981 with very little apparent need for change in policies or procedures.

UNIVERSAL APPLICATION FORM FOR GRADUATE MEDICAL EDUCATION

The Association's Task Force on Graduate Medical Education recommended that to assist students during their transition from undergraduate to graduate medical education a universal application form should be developed. The purpose would be to reduce the need for students to write for multiple applications and provide diverse information in varying formats.

Based upon an analysis of over 100 forms, the staff of the Division of Student Programs developed a draft form in 1979. This was distributed to program directors through hospital NRMP coordinators, to student affairs deans in the medical schools and to selected students. Critical comments and suggestions were requested. Based on the returns from that distribution, the draft form was revised and in July 1980 the revision was sent to program directors through hospital NRMP coordinators with the request that a response be returned indicating whether the form would be acceptable. The results of this survey are shown below.

Total hospitals mailed to:	671
Total programs represented:	2996*
Number of responses received:	358 (53% of total mailed to)
No. of programs represented:	1516 (50% of total represented)
Hospitals accepting form:	299 (84% of response)
No. of programs represented:	1067 (70% of response)
Hospitals not accepting form:	19 (5% of response)
No. of programs represented:	92 (6% of response)
Hospitals reporting split reaction:	40 (11% of response) 262/357 programs accept form (18% of response) 95/357 programs do not accept form (6% of response)
Total no. of programs accepting form:	1329 (88% of response)

*This number is based upon entries in the NRMP Directory for 1980 Appointments. It includes programs starting at other than the first year of graduate medical education. Also, in many cases, the number of programs reported by the hospitals differs from the number shown in the Directory.

The Executive Council has authorized the implementation of the Universal Application Form in the spring of 1981 for students applying to programs for their first graduate year starting in 1982.

The form will be provided to medical schools in sufficient numbers so that students may send an original copy to each program to which they apply. However, the form is designed so that biographic information commonly required by all hospitals and programs is on pages three and four. These pages could be prepared once and duplicated.

Programs requiring additional information will be free to request that applicants submit a supplementary form.

An acknowledgement card to inform applicants of the receipt of the application and a program designation card for the use of the program or hospital is included with each form.

With over 95 percent of a larger and larger graduating class applying for graduate medical education, the introduction of a universal application form is one step toward reducing the strain of the transition between undergraduate and graduate medical education for students and for programs.

EXTERNAL EXAMINATION REVIEW COMMITTEE

In June 1980, the Executive Council appointed a committee to review the status of external examinations in medical education. The committee is chaired by Carmine Clemente and is charged to consider the development of the Comprehensive Qualifying proposal by the National Board of Medical Examiners as an examination which students would have to pass to enter the graduate phase of their education. The parallel development of a proposal by the Federation of State Medical Boards to develop a two phased licensing examination system in the states will also be scrutinized. The Federation has proposed that the state licensing boards should require passage of an examination for a preliminary license for residents to participate in patient care under supervision in educational settings. This examination has been termed the Federation Licensing Exam I (FLEX I). There is an assumption that the National Board of Medical Examiners' Comprehensive Qualifying Exam would be FLEX I. Passage of a second exam would be required for licensure for independent practice. Eligibility to sit for this exam (FLEX II) would require completing a period of graduate medical education.

The committee will review the potential impact of these developments on medical education and on the relationship between the National Board of Medical Examinators, medical school faculties and the Federation of State Medical Boards.

A major discussion of the status of development of the Comprehensive Qualifying Exam and policies relating to it is planned for the Council of Academic Societies Interim Meeting in February.

COMMITTEE MEMBERSHIP

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OSR Representative
Hahnemann Medical College

GENERAL ACCOUNTING OFFICE STUDY OF U.S. CITIZENS IN FOREIGN MEDICAL SCHOOLS

During 1979-80, the General Accounting Office undertook a study of U.S. citizens studying medicine abroad at the request of the House Subcommittee on Health and Environment. The Congress was concerned about the adequacy of medical education provided to U.S. citizens studying abroad and the impact of their returning to the United States with the expectation of developing careers as practicing physicians in this country at a time when our own domestic schools are facing resource curtailments. The growing perception of a possible physician surplus was also a concern. Additionally, through authorities established in the Higher Education Act of 1966, the Department of Education has provided guaranteed student loans to U.S. citizens studying abroad if such education is comparable to the education they might receive in this country. The Department of Education has never established standards of comparability for medical education in foreign institutions.

The study focused on six schools which the GAO estimated enrolled one-half of the U.S. citizens studying abroad. They were: University Central del Este, Dominican Republic; University of Nordestana, Dominican Republic; St. George's University, Grenada; Autonoma University of Guadalajara, Mexico; University of Bologna, Italy and the University of Bordeaux, France.

The study found major differences between these six institutions and U.S. medical schools in their admission requirements, facilities, equipment, faculty, curricula and clinical training resources. The GAO has not made a formal presentation of its findings or recommendations to the Congress. Dr. Murray Grant, Medical Consultant to the General Accounting Office, will present a summary of the report at the Assembly Meeting on Tuesday morning, October 28th. The timing of the release of the official report and a response by the Association to the draft report which staff has reviewed will depend upon the Congressional schedule during the post-election period.

CLINICAL LABORATORY REGULATION

The regulation of clinical laboratories is of interest to AAMC organizations for several reasons: Proposals for change would extend regulatory coverage to clinical research laboratories. Also regulated would be specialized clinical laboratories operated by such specialists as anesthesiologists, cardiologists, endocrinologists and emergency physicians. In addition, existing hospital clinical laboratories would be saddled with new reporting and staffing requirements which would escalate costs without improving the quality of these laboratories to any significant extent.

During the past year there have been both legislative and executive branch actions to extend regulation of clinical laboratories. The Congress quietly attempted to extend the 1967 law (which covers only interstate laboratories) to those laboratories which receive Medicare or Medicaid payments, that is to all laboratories. This effort was embodied in the 1980 Medicare Amendments, H.R. 4000. The attempt was discovered at the eleventh hour and appears to have been defeated largely due to the efforts of Congressman Satterfield (D-Va.) who introduced substitute language restraining the proposed Medicare extension and actually restricting efforts (see below) of the Department of Health and Human Services (DHHS) to impose further laboratory regulations. Neither provision passed in the regular session and the off-setting provisions and controversy engendered make it likely that neither will succeed in the lame duck session. Congressman Satterfield will not return to Congress next year. If Senator Javits (the main proponent of CLIA) is re-elected, another attempt is likely to be made in 1981.

In parallel but not directly related activities, DHHS proposed new regulations in October 1979 to prescribe credentials for all personnel who direct and work in clinical laboratories. Although these regulations were four years in the making, they pleased no one and generated more than 7000 written objections. Secretary Harris ordered the Center for Disease Control and Health Care Financing Administration to hold a joint conference to work out the problems and find solutions. Most observers at the August conference agreed that there was much heat, little light, and even less agreement. Thus, it surprises no one that rumors are now prevalent that Secretary Harris will withdraw the proposed regulations requiring credentialling of laboratory personnel. Meanwhile, just in case either Congress or the DHHS begin to move again, several CAS societies have been quietly working to draft more reasonable proposals by which those laboratories which need assistance could really be upgraded.

DISPOSAL OF HAZARDOUS WASTES

In 1979 the three national sites for disposal of radioactive waste (in South Carolina, Washington and Nevada) were closed for a short period of time due to irregularities in the packaging and transportation of wastes from nuclear power plants. Biomedical research institutions, hospitals and radiopharmaceutical manufacturers also generate radioactive wastes which amount to between 10 and 15 percent of the total annual volume shipped to the national sites. This volume consists mostly of scintillation vials, carcasses and biological wastes. It is growing each year but is dwarfed by the wastes from a single nuclear power plant "clean-up" such as Three Mile Island. Biomedical wastes of low volume and very low specific activity must continue to flow steadily to the national sites because the storage capacity of bio-research institutions and hospitals is very limited.

It was largely the threat to the bio-research/hospital endeavor which prompted the sympathetic Washington State Governor, Dixy Lee Ray, to reopen the Hanford, Washington site in late 1979. Most observers felt this re-opening would be very temporary; therefore, the AAMC took steps to find ways to alleviate the problem during the respite provided by Governor Ray's action. Despite our best efforts, however, problems related to the disposal of hazardous wastes continue to evolve in a complex and uncertain way. With respect to radioactive wastes, AAMC has sought to gain acceptance for the concept of de minimus levels which would be those below which substances would not be regarded as radioactive. Efforts to set a de minimus level have not been entirely successful. The Presidential Radiation Policy Council and the Nuclear Regulatory Commission are expected to propose soon that scintillation vials and animal carcasses containing tritium or carbon-14 of low specific radioactivity can be treated as ordinary trash and disposed of by local burial or incineration. The Association's advisors feel that such a proposal would not completely solve the problem of medical schools and hospitals but that the change would help considerably. The disposal issue is further complicated by the combination of the primary election loss of Governor Ray to an opponent with strong environmentalist backing and an environmentalist-sponsored referendum on the November 4 ballot which is expected to force the closure of the Hanford site to nuclear power wastes. Although biomedical wastes could still be accepted the site operator has stated publicly that such a low-volume operation would not be feasible and that he would cease operation anyway.

The Federal initiatives may help institutions to dispose locally of some low-level wastes now regarded as radioactive. However, this advantage is likely to be short-lived as the Environmental Protection Agency (EPA) proposes new and more stringent regulations for the disposal of animal and toxic chemical wastes. Although Association staff have been unable to penetrate EPA for a preview of the animal/microbiological regulations we are not encouraged by the adjectives ("draconian,""stringent" and "foolish") used by knowledgeable consultants to describe these rules. Regulations promulgated by EPA on August 18 require the collection, labelling and control of toluene (the principal component of scintillation fluid) and dozens of other common laboratory chemicals. At this time, however, it is not clear whether or by what means local disposal of such toxic chemicals will be allowed. It is safe to predict that whatever will be permitted by EPA will be even more expensive than the present arrangements.

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE'S REPORT

The Graduate Medical Education National Advisory Committee submitted its report to the Secretary of HHS on September 30. GMENAC was chartered by the then Secretary of HEW Matthews in 1976; and its original membership was appointed by him in the waning days of the Ford Administration. Its charge was--"to advise the Secretary on the number of physicians required in each specialty to bring supply and requirements into balance, methods to improve the geographic distribution of physicians and mechanisms to finance graduate medical education".

GMENAC's prediction of requirements for physicians in the future are based upon a complex modeling process derived from data on the prevalence of disease, estimations of the need for physicians to provide services for various conditions, estimations of the services that could be provided by other health professionals and the productivity of physicians and other health professionals. Based upon this complex modeling process, GMENAC predicts that there will be 70,000 more physicians than required by 1990; and that all but seven specialties and subspecialties will be in over supply (see Figure 1, page 52).

Last spring the Association commented upon the modeling process being used by GMENAC and expressed its concerns that the process could not take into account the changes in physician services that will be required due to unforeseeable changes in knowledge and new technological developments. Concerns were also expressed about the heroic assumptions that the panelists had to make regarding future consumer preferences, future resources to be allocated to medical services and the future productivity of physicians.

The report contains forty recommendations (see pages 53 - 55). There has not been sufficient time to analyze the report thoroughly. The recommendations which may have significant impact on the medical schools and their undergraduate and graduate programs are denoted with a "O".

1. A reduction in the entering class of 1984 to a level of 10 percent less than the entering class of 1978 is recommended. Based upon the projected class size of 1982, this would mean a reduction from 18,151 to 14,833, an overall decrease of 18 percent. Such a rapid change will be difficult to accomplish since the decision to diminish the size of any school's entering class will require an assessment of the impact on the institution, the state and the region. As an example, Ohio has four state medical schools which, in 1982, are projected to enroll 606 first year students. An 18 percent reduction by 109 positions would nearly be the equivalent of the entering class size of three of the four schools. In neighboring Indiana, with only one medical school, an 18 percent reduction would mean a decrease in entering class size from 318 to 261. The table beginning on page 56 shows the estimated reductions required in each medical school.

2. GMENAC estimates that by 1983 4,100 graduates of foreign medical schools will be entering the United States yearly and recommends that this number should be severely restricted. If it cannot be, it is GMENAC's view that the enrollment in domestic medical schools should be curtailed even further. Eight supportive recommendations are particularly targeted toward reducing the number of U.S. citizens enrolling in foreign schools with the expectation that they will be accommodated in this country's health care system. These recommendations, plus the findings to be reported by the General Accounting Office from their study of six foreign medical schools, may make policymakers

more resistent to the demands of lobby groups which are seeking special privileges for U.S. citizens enrolled in foreign schools.

4. It is recommended that no specialty should be expected to increase or decrease the number of first year positions in its graduate medical programs by more than 20 percent between 1980 and 1986. Table 6 on page 62 is included in the report to show illustrative rates of entry into first year graduate positions in 1986. The inclusion of this table was heatedly debated by GMENAC members. Those opposed believe that the specificity of the entry rates cannot be justified because the predicted surpluses or shortages in each specialty are not sufficiently exact. They were fearful that even though the table is labeled "illustrative rates" the numbers will be viewed as recommended targets and attempts to implement them either through national or local policy decisions might occur even on a shorter time span than six years.

5. It is recommended that graduates should be encouraged to enter specialties predicted to be in short supply by 1990 or to enter the primary care specialties. The latter recommendation is somewhat contradictory since primary care specialties are predicted to be in excess.

14. Recommends that analyses of medical services needed in geographic regions be based upon specialty-specific functional medical service areas. This approach, rather than the usual analyses by geopolitical units, may provide more rational assessments of the geographic distribution of physicians.

24. Calls for medical students and junior residents to have a broad-based education in the generalist clinical fields. It is not clear whether GMENAC intended to support the idea generated in other quarters that all students should be required to take a broad-based clinical first graduate year.

26. Recommends that medical schools increase the diversity of their enrolled students by promoting more flexibility in admission requirements and by broadening the characteristics of the applicant pool with respect to age, sex, race, and socio-economic status. Since an economic barrier is likely to be a major impediment to diversity, the Committee's recommendation that loans and scholarships be provided to support the schools' continuing efforts to maintain diversity is welcome.

28. Recommends discontinuing capitation grants based upon enrollment increases. GMENAC is silent on the need for continued Federal participation in the support of medical education through the provision of flexible institutional support.

32. Recommends that graduate medical education should be principally financed through the normal rate structure for patient care in teaching hospitals and that the cost should be equitably borne by all payors. GMENAC goes on to call for a uniform reporting system directed toward distinguishing educational costs from patient care costs. A multi-million dollar study has been instituted by DHHS to once again attempt to separate educational costs from patient care costs in the teaching setting. The inextricable intertwining of patient care with education in teaching hospitals is not likely to be untangled by further studies or by any uniform reporting system.

34. GMENAC supports paying teaching physicians professional fees "--when their services have been identifiably discreet and necessary." This is the only

reference to the issues surrounding the implementation of Section 227 of the Medicare Amendments.

38. Recommends that the development of academic medical faculty be supported through adequate financing for their training. Approaches to financing are not specified.

39. The Committee calls for continued collaboration between health professionals and government in manpower planning and recommends that there be a successor to GMENAC on the basis that there will be a continuing need to monitor the supply of physicians and to refine and update estimations of requirements. It is stated that such a successor should be advisory and not regulatory. No mention is made of the role existing Federal agencies, such as the National Center for Health Services Research and the National Center for Health Statistics, could play in lieu of creating another advisory body.

Ratio % of Projected Supply to Estimated Requirements-1990

		Ratio%	Requirements	Surplus (shortage)
Shortages	Child Psychiatry	45%	9,000	(4,900)
	Emergency Medicine	70%	13,500	(4,250)
	Preventive Medicine	75%	7,300	(1,750)
	General Psychiatry	80%	38,500	(8,000)
Near Balance	Hematology/Oncology-Internal Medicine	90%	9,000	(700)
	Dermatology	105%	6,950	400
	Gastroenterology-Internal Medicine	105%	6,500	400
	Osteopathic General Practice	105%	22,000	1,150
	Family Practice	105%	61,300	3,100
	General Internal Medicine	105%	70,250	3,550
	Otolaryngology	105%	8,000	500
	General Pediatrics and Subspecialties	115%	36,400	4,950
Surpluses	Urology	120%	7,700	1,650
	Orthopedic Surgery	135%	15,100	5,000
	Ophthalmology	140%	11,600	4,700
	Thoracic Surgery	140%	2,050	850
	Infectious Diseases-Internal Medicine	145%	2,250	1,000
	Obstetrics/Gynecology	145%	24,000	10,450
	Plastic Surgery	145%	2,700	1,200
	Allergy/Immunology-Internal Medicine	150%	2,050	1,000
	General Surgery	150%	23,500	11,800
	Nephrology-Internal Medicine	175%	2,750	2,100
	Rheumatology-Internal Medicine	175%	1,700	1,300
	Cardiology-Internal Medicine	190%	7,750	7,150
	Endocrinology-Internal Medicine	190%	2,050	1,800
	Neurosurgery	190%	2,650	2,450
	Pulmonary-Internal Medicine	195%	3,600	3,350
	*Physical Medicine and Rehabilitation	75%	3,200	(800)
	*Anesthesiology	95%	21,000	(1550)
	*Nuclear Medicine	N/A	4,000	N/A
	*Pathology	125%	13,500	3,350
	*Radiology	155%	18,000	9,800
	*Neurology	160%	5,500	3,150

*The requirements in these six specialties were estimated crudely after a review of the literature. They should be considered as very rough approximations, and tentative. The full GMENAC modeling methodology will be applied to them in 1980-1981.

The assumptions used to project 1990 supply numbers are stated in case 2, in Notes to FIGURE 2, and in footnote a), TABLE 1.

Supply numbers for Nuclear Medicine are not available.

FIGURE 1

Advisory Panel's Recommendations on Medical Education

from the Chronicle of Higher Education - October 6, 1980

WASHINGTON

Following is the text of recommendations in the summary report of the federal government's Graduate Medical Education National Advisory Committee. The committee's summary condenses 107 recommendations included in its complete six-volume report to Secretary of Health and Human Services Patricia R. Harris.

1 Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of 10 per cent by 1984 relative to the 1978-79 enrollment or 17 per cent relative to the 1980-81 entering class.

Supportive recommendations:

A. No new allopathic or osteopathic medical schools should be established beyond those with first-year students in place in 1980-81.

B. No increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981 should occur.

C. The current Health Professions Law, which authorizes grants to health professions schools for construction of teaching facilities, should be amended to allow the Secretary of the Department of Health and Human Services to grant waivers to allow them to ignore the law's requirement to increase enrollment. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants' Program.

D. The current Health Professions Law should be amended to allow the Secretary of the Department of Health and Human Services to waive immediately the requirement that allopathic and osteopathic medical schools, as a condition of receiving a capitation grant, maintain the first-year enrollment at the level of the preceding school year. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants' Program.

2 The number of graduates of foreign medical schools entering the U. S. yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished, the undesirable alternative is to decrease further the number of entrants to U. S. medical schools.

Supportive recommendations:

A. All federal and state assistance given through loans and scholarships to U. S. medical students initiating study abroad after the 1980-81 academic year should be terminated.

B. The current efforts in the private sector to develop and implement a uniform qualifying examination for U. S. citizens and aliens graduating from medical schools other than those approved by the L.C.M.E. (Liaison Committee for Medical Education) as a condition for entry into L.C.G.M.E. (Liaison Committee for Graduate Medical Examination) approved graduate training programs should be supported. Such an examination must assure a standard of quality equivalent to the standard applied to graduates of Liaison Committee on Medical Education accredited medical schools. These U. S. citizens and aliens must be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination. The Educational Commission for Foreign Medical Graduates (E.C.F.M.G.) examination should not be used as the basis for measurement of the competence of [American graduates of foreign medical schools] or alien physicians.

C. Alien physicians, who enter the United States as spouses of U. S. citizens, should be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination prior to entry into residency training.

D. The ability to read, write, and speak English should remain a requirement for graduate medical education programs for all alien physicians.

E. The Federation of State Medical Boards should recommend and the states should require that all applicants successfully complete at least one year of a G.M.E. [graduate medical-education] program that has been approved by the L.C.G.M.E. and successfully pass an examination prior to obtaining unrestricted licensure. The examination should assure a standard of quality in the ability to take medical histories, to do physical examinations, to carry out procedures, and to develop diagnostic and treatment plans for patients. The standard of quality should be equivalent to graduates of United States medical schools.

F. The states should severely restrict the number of individuals with limited licenses engaged in the practice of medicine. This restriction applies to those practicing independently without a full license and to those practicing within an institution without adequate supervision.

G. The "fifth Pathway" for entrance to approved programs of graduate medical education should be eliminated.

H. The transfer of U. S. citizens enrolled in foreign schools into advanced standing in U. S. medical schools should be eliminated.

3 The need to train nonphysician health care providers at current levels should be studied in the perspective of the projected oversupply of physicians.

4 To correct shortages or surpluses in a manner not disruptive to the G.M.E. system, no specialty or subspecialty should be expected to increase or decrease the number of first-year trainees in residency or fellowship training programs more than 20 per cent by 1986 compared to the 1979 figure.

5 In view of the aggregate surplus of physicians projected for 1990, medical school graduates in the 1980's should be strongly encouraged to enter those specialties where a shortage of physicians is expected or to enter training and practice in general pediatrics, general internal medicine, and family practice.

6 Extensive research on the requirements for N.P.'s [nurse practitioners], P.A.'s [physician's assistants,] nurse-midwives, and other nonphysician providers should be undertaken as soon as possible. Special attention must be given to the effect of a physician excess on their utilization and to the benefits these providers bring to health care delivery. These studies should consider the full range of complementary and substitute services.

7 Until the studies in Recommendation 6 have been completed, the number of P.A.'s, N.P.'s, and N.M.W.'s [nurse-midwives] in training for child medical care, adult medical care, and obstetrical/gynecological care should remain stable at their present numbers. Delegation levels recommended by G.M.E.N.A.C. for 1990 are: in obstetrics/gynecology 197,000 of the normal uncomplicated deliveries (5 per cent of all deliveries), 7.1 million maternity-related visits (20 per cent of the obstetrical caseload), and 7.5 million gynecological visits (19 per cent of the gynecological caseload); in child care not more than 46 million ambulatory visits (16 per cent of the child ambulatory caseload; and in adult medical care not more than 128 million ambulatory visits (12 per cent of the adult medical ambulatory caseload).

8 All incentives for increasing the class size or the number of optometric or podiatric schools should cease until the studies in Recommendation 6 have been completed and evaluated.

9 State laws and regulations should not impose requirements for physician supervision of N.P.'s and P.A.'s, beyond those needed to assure quality of care.

Supportive recommendations:

A. State laws and regulations should be altered as necessary so that a P.A. or N.P. working under appropriate physician supervision can independently complete a patient encounter for conditions which are deemed delegable.

B. The states should provide P.A.'s, N.P.'s, and nurse-midwives with limited power of prescription, taking necessary precaution to safeguard the quality of care including explicit protocols, formularies, and mechanisms for physician monitoring and supervision.

C. At a minimum, P.A.'s, N.P.'s, and nurse-midwives should be given power to dispense drugs in those settings where not to do so would have an adverse effect on the patient's condition.

D. States, particularly those with underserved rural areas, should evaluate whether the laws and regulations pertaining to nonphysician practice discourage nonphysician location in these areas.

10 The requirements of third party payors for physician supervision should be consistent with the laws and regulations governing nonphysician practice in the state.

11 Medicare, Medicaid, and other insurance programs should recognize and provide reimbursement for the services by N.P.'s, P.A.'s, and nurse-midwives in those states where they are legally entitled to provide these services. Services of these providers should be identified as such to third party payors and reimbursement should be made to the employing institution or physician.

12 N.P.'s, P.A.'s, and nurse-midwives should be eligible for all federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps Scholarship Program.

13 Graduate medical education should be constructed to give residents experience in working with P.A.'s, N.P.'s, and nurse-midwives to insure that these physicians will be prepared to utilize nonphysician services.

14 G.M.E.N.A.C. recommends that the basic unit for medical manpower planning should be a small geographic area within which most of the population receives a specified medical service. These functional medical service areas, service by service, are recommended as the geographic units for assessing the adequacy of manpower supply.

15 G.M.E.N.A.C. encourages the support of efforts within the profession to assess the outcomes of common medical and surgical practices exhibiting high variation across communities. Accomplishing this step would help to establish long-range requirements for physician services in the United States.

16 Variations between communities in the utilization of specific medical services should be continu-

17 G.M.E.N.A.C. recommends that health manpower shortage area be defined by a minimum service specific physician to population ratio and a maximum travel time to service for child care, adult medical care, obstetrical services, general surgical services, and emergency medical services.

Supportive recommendations:

A. The minimum acceptable physician to population ratio for any area in the U. S. should be 50 per cent of the requirements estimated by G.M.E.N.A.C. for each type of health service in the nation as a whole.

B. Maximum travel times to service for 95 per cent of the population within a geographic area should be 30 minutes for child care, adult medical care, and emergency medical service; 45 minutes for obstetrical care; and 90 minutes for general surgical services.

18 Alternative data systems for monitoring the geographic distribution of physicians should be developed and evaluated.

19 Medical students should be encouraged to select a location for practice in underserved rural and urban areas by several approaches: (1) urban and rural preceptorships should be continued and expanded by those schools having an interest, (2) governmental loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving geographic distribution, (3) loan forgiveness programs modeled after those which have been successful should be used, and (4) the National Health Service Corps and its scholarship program should be supported.

20 The medical profession in making decisions as to residency training programs should consider the aggregate number of programs, their size, and the geographic distribution of their graduates, in addition to the quality of the program, in light of national and regional needs.

21 Family practice residency training programs should be supported since these programs tend to train providers who are more likely to choose to practice in underserved areas.

A similar rationale underlies support needed for resident experiences in underserved areas and for certain nonphysician provider training programs.

22 Area-wide programs of decentralized medical education and service such as W.A.M.I. (Washington, Alaska, Montana, and Idaho), W.I.C.H.E. (Western Interstate Commission for Higher Education), and some A.H.E.C.'s (Area Health Education Centers) should be evaluated for replicability. Such programs have been effective in placement of physicians in sparsely populated areas.

23 More research and evaluation should be conducted on factors relating to the geographic distribution of physicians.

24 Medical education in the medical schools and in the early phase of graduate medical education in the teaching hospitals should provide a broad-based clinical experience with emphasis on the generalist clinical fields. A portion of graduate medical training should occur in other than tertiary care medical centers.

25 A more vigorous and imaginative emphasis should be placed on ambulatory care training experiences.

Supportive recommendations:

A. The out-patient services of the academic medical centers should be upgraded through special project grants.

B. Educational innovation in outpatient settings should be fostered by providing financial support.

C. Faculty should be encouraged and supported to develop careers focused on ambulatory medicine through a career development award mechanism.

26 Greater diversity among the medical students should be accomplished by promoting more flexibility in the requirements for admission; by broadening the characteristics of the applicant pool with respect to socio-economic status, age, sex, and race; by providing loans and scholarships to help achieve the goals; and by emphasizing, as role models, women and under-represented minority faculty members.

27 Information about physician manpower needs in the various specialties and in different geographic settings should be disseminated broadly to medical schools; administrators; faculty; and medical students, residents, fellows, and spouses.

28 Capitation payments to medical schools for the sole purpose of increasing class size or for influencing specialty choice should be discontinued in view of the impending surplus of physicians.

29 Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued in order to continue and to increase the emphasis on primary care services and ambulatory care.

Supportive recommendations:

A. Family practice programs, at least for the near term, should be given special attention in view of the difficulty in financing training programs from ambulatory care revenues.

B. Specialties in short supply should be considered for special project grants.

30 Ambulatory care training should be promoted further by the provision of grants for renovation and construction of facilities, for the support of training programs in ambulatory sites, and for student preceptorships and residency experiences in out-of-hospital care.

31 The medical profession, having the major responsibility for correcting physician oversupply, should insure the quality of all graduate medical education programs and full funding of these programs through reimbursement should be given only to accredited programs when mechanisms are in place.

32 Calculations of the true costs of graduate medical education should include the compensation for residents and teaching personnel and all of the ancillary and indirect costs, should distinguish between the cost of education and the cost of patient care by a uniform recognized reporting system. Costs should be borne equitably by all payors as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided to the extent that such costs are not financed by tuition, grants, or other sources of revenue.

33 The health professions should assume a major responsibility for cost containment in new program development, in accreditation and certification, and in the provision of health services.

34 Public and private reimbursement policies should be adjusted to: emphasize ambulatory care services and training; encourage practice in underserved areas; explore the concept of shared risk among physicians; and pay professional fees to teaching physicians where their services have been identifiably discrete and necessary.

35 Continuous monitoring and evaluation of existing and new financial programs should be supported. Actions undertaken to alter financing and reimbursement strategies should not be advanced as permanent mechanisms for change until adequate evaluation/demonstration efforts have been performed.

36 Additional research should be accomplished on a broad array of topics related to financial considerations.

37 Special project grants for states on a cost sharing basis should be considered to influence the geographic distribution of physicians within the states. The development of incentives for practice in underserved areas is one program to be considered.

38 The development of future medical faculty, administrators, and researchers should be assured by provision of adequate financial support for their training.

39 A successor to the Graduate Medical Education National Advisory Committee should be established by statute. This successor should be an advisory body without regulatory functions.

40 In addition to the continuous monitoring, the supply projections, requirements estimates, and recommendations of G.M.E.N.A.C. in their entirety must be reevaluated and modified at least every five years to take account of changes in data, assumptions, and priorities occurring over time.

EFFECTS OF GMENAC'S RECOMMENDED REDUCTION IN FIRST YEAR ENROLLMENT

Fully-Accredited Medical Schools	1978[1] 1st Year Enrollment	1982 Projection[2] 1st Year Enrollment	10% Reduction[3] 1978 1st Year Enrollment	Projected 1982[4] 1st Year Enrollment Reduced by 18%
Alabama	169	170	152	139
Alabama, South	70	70	63	57
Albany	128	128	115	105
Albert Einstein	186	188	167	154
Arizona	88	89	79	73
Arkansas	138	145	124	119
Baylor	167	169	150	139
Boston University	141	139	127	114
Bowman Gray	107	113	96	93
Brown	62	60	56	49
U. California, Davis	102	100	92	82
U. California, Irvine	106	109	95	89
U. California, Los Angeles	145	146	131	119
U. California, San Diego	129	129	116	106
U. California, San Francisco	159	159	143	130

[1]Source: AAMC Medical School Admission Requirements, 1980-81.

[2]For fully-accredited medical schools 1979 first year enrollment was used as a projection for 1982 first year enrollment. For provisionally-accredited schools the 1982 first year enrollment projection was based on figures from Medical Schools of the U.S.A., Status of Accreditation, June 20-21, 1980.

[3]GMENAC's recommendation is for a 10% aggregate decrease in first year enrollment based on 1978 entering class size.

[4]An 18% reduction from 1982 first year enrollment is required to meet GMENAC's recommendation for a 10% aggregate decrease from 1978 first year enrollment figures.

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
U. Southern California	136	144	122	118
Case Western Reserve	147	146	132	120
Chicago Medical	120	119	108	98
U. Chicago--Pritzker	104	104	94	85
Cincinnati	199	198	179	162
Colorado	128	129	115	106
Columbia	150	149	135	122
Connecticut	83	82	75	67
Cornell	96	105	86	86
Creighton	109	113	98	93
Dartmouth	67	65	60	53
Duke	120	119	108	98
Emory	115	112	103	92
Florida	116	117	104	96
Florida, South	96	99	86	81
Georgetown	205	206	185	169
George Washington	155	152	140	125
Georgia	181	185	163	152
Hahnemann	192	190	173	156
Harvard	167	166	150	136
Hawaii	68	68	61	56
Howard	139	143	125	122
Illinois	344	354	310	290
Illinois, Southern	74	73	67	60

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
Indiana	320	318	288	261
Iowa	175	177	156	145
Jefferson	235	223	212	183
Johns Hopkins	121	120	109	98
Kansas	202	202	182	166
Kentucky	110	110	99	90
Loma Linda	149	150	134	123
Louisiana, New Orleans	183	192	165	157
Louisiana, Shreveport	106	104	95	85
Loyola--Stritch	153	152	138	125
Maryland	181	181	163	148
Mayo	41	41	37	34
Meharry	149	156	134	128
Miami	144	180	130	148
Michigan State	117	110	105	90
U. Michigan	247	244	222	201
Minnesota--Duluth	48	48	43	39
Minnesota--Minneapolis	243	251	219	206
Mississippi	154	153	139	125
Missouri, Columbia	113	111	102	91
Missouri, Kansas City	83	84	75	69
Mount Sinai	102	103	92	84
Nebraska	152	154	137	126
Nevada, Reno	49	49	44	40

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
New Jersey Medical	154	179	139	147
Rutgers	114	110	103	90
New Mexico	75	73	68	60
New York Medical	180	181	162	148
New York University	171	173	154	142
SUNY--Buffalo	142	138	128	113
SUNY--Downstate	221	225	199	185
SUNY--Stony Brook	63	60	57	49
SUNY--Upstate	150	150	135	123
North Carolina	161	162	145	133
North Dakota	67	68	60	56
Northwestern	177	173	159	142
Ohio, Medical College of	133	142	120	116
Ohio State	251	258	226	212
Oklahoma	178	176	160	144
Oregon	117	116	105	95
Pennsylvania, Medical College of	102	104	92	85
Pennsylvania State	97	99	87	81
U. Pennsylvania	160	160	144	131
Pittsburgh	136	139	122	114
Rochester	101	97	91	80
Rush	122	120	110	98
St. Louis University	155	155	140	127
South Carolina, Medical Univ. of	169	167	152	137

Fully-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
South Dakota	68	66	61	54
Stanford	86	86	77	71
Temple	184	187	166	153
U. Tennessee	221	215	199	176
U. Texas, Dallas	207	207	186	170
U. Texas, Galveston	208	206	187	169
U. Texas, Houston	159	214	143	175
U. Texas, San Antonio	214	208	193	171
Texas Tech	62	84	56	69
Tufts	151	149	136	122
Tulane	150	151	135	124
Uniformed Services	108	129	97	106
Utah	102	100	92	82
Vanderbilt	104	106	94	87
Vermont	83	93	75	76
Virginia, Eastern	80	99	72	81
Virginia, Medical College of	168	168	151	138
U. Virginia	138	143	124	117
Washington U. (St. Louis)	128	124	115	102
U. Washington	175	181	158	148
Wayne State	256	257	230	211
West Virginia	88	89	79	73
Wisconsin, Medical College of	180	201	162	165
Wright State	79	106	71	87
Yale	102	102	92	84

Provisionally-Accredited Medical Schools	1978 1st Year Enrollment	1982 Projection 1st Year Enrollment	10% Reduction 1978 1st Year Enrollment	Projected 1982 1st Year Enrollment Reduced by 18%
Morehouse	27	64	22	52
East Carolina	37	64	33	52
Northeastern Ohio	49	100	44	82
Oral Roberts	25	48	23	39
Puerto Rico, Ponce	28	60	25	49
Puerto Rico, Escuela de Medicine de Cayey	80	80	72	66
U. South Carolina	37	64	33	52
East Tennessee	24	72	22	59
Texas A & M	32	96	29	79
Marshall University	26	48	23	39
TOTALS	16,501	18,151	14,851	14,883

TABLE 6

ILLUSTRATIVE RATES OF ENTRY INTO
FIRST-YEAR GRADUATE MEDICAL EDUCATION PGY-1 IN 1986

	PROJECTED 1990 SURPLUS (SHORTAGE)	1979 GME ENTRY RATES AT PGY-1 LEVEL	1986 ILLUSTRATIVE TREND PERCENT CHANGE	1986 GME ENTRY RATES AT PGY-1
TOTAL		20,474	-2	20,030
Osteopathic Interns	1,150	1,050	-2	1,030a/
Flex Interns	N.A	1,325	+15	1,500b/
Family Practice	3,100	2,347	c/	2,347
General Pediatrics and Subspecialties	4,950	2,030	c/	2,030
General Internal Medicine	3,550	6,730	c/	6,730
OB/GYN	10,450	1,100	-20	880
*Neurology	3,150 *	113	0	113
Dermatology	400	13	0	13
Psychiatry	(8,000)	714	+20	856
General Surgery	11,800	2,817	-20	2,254
Neurosurgery	2,450	31	-20	25
Ophthalmology	4,700	65	-20	52
Orthopedic Surgery	5,000	240	-20	192
Otolaryngology	500	40	0	40
Urology	1,650	60	-2	48
Emergency Medicine	(4,250)	225	N.A. d/	400
*Anesthesiology	(1,550)*	400	-10	510
*Pathology	3,350 *	559	-5	531
*Physical Med. & Rehab.	(800)*	85	+20	102
*Radiology	9,800 *	470	-20	376

a/ Derived using the same proportional decrease (minus 2 percent) in the total number of positions for allopathic medicine between 1979-80 and 1986-87.

b/ These positions provide the first year clinical training for several specialties and are likely to be called the transitional year in the future. Therefore, GMENAC suggests a 15 percent increase in the number of these positions.

c/ While the 1990 projected supply is slightly greater than requirements for all three of these specialties, GMENAC suggests that the current number of available positions be retained in order to accommodate as many residents as possible in these three, as opposed to other, specialties.

d/ See Note 7 in NOTES to TABLES 1-7 on page 14.

* The requirements in these five specialties were estimated crudely after a brief review of the literature. They should be considered approximations, and tentative. The full GMENAC modeling methodology will be applied to them in 1980-81.

MEDICARE'S ALTERED POLICY ON REIMBURSEMENT OF "MOONLIGHTING" RESIDENTS

Two years ago, Medicare officials found that residents in the Welsey Medical Center in Wichita, Kansas, were being compensated by a physician group operating the Center's emergency room. Services provided by residents working in a "moonlighting" status were billed on a fee for service basis in the name of the group. This payment to residents for services in a "moonlighting" status in the same institution providing their graduate education was counter to Medicare policy and reimbursement under Part B was disallowed. The hospital sued the Secretary of HEW alleging that because "moonlighting" residents could be paid on a fee for service basis in settings other than in the hospital responsible for their graduate medical education, the policy disallowing reimbursement for services in their emergency room was arbitrary, capricious and discriminating. The Federal District Court in Kansas agreed and ordered Medicare to change the policy.

Medicare's proposed policy change will permit "moonlighting" residents to be paid on a fee for service basis regardless of the hospital in which the service is provided. The proposed policy requires that, "the 'moonlighting' services are performed under the terms of a written contract or agreement and can be separately identified from those services that are required as part of the training program" (see page 65). This change in Medicare policy, which resulted from a court order, is not likely to be reversible. It may result in significant problems for the following reasons:

1. Separating patient care responsibilities which are necessary for education from patient care responsibilities which are not necessary for education and setting these down in a written agreement will be difficult, given the non-specific nature of the special requirements of most residency review committees;

2. Some hospitals in order to attract residents or to reduce their obligation to pay increased stipends from hospital reimbursements may provide "in-house moonlighting" opportunities by arbitrarily limiting the service responsibilities for their educational programs, thus freeing time for residents to work as physicians in their facilities rather than being in an educational status.

In 1974, the Association adopted the following policy on "moonlighting":

> Graduate medical education should be a full time educational experience. House officers should not be diverted from their primary responsibilites to their own education and to the patients charged to their care by the training institution by engaging in extramural professional activities. Therefore, as a matter of general principle, the Association of American Medical Colleges believes that "moonlighting" by house officers is inconsistent with the education objectives of house officer training and is therefore a practice to be discouraged.
>
> For those institutions which permit "moonlighting," great care should be taken to preserve the educational character of their graduate medical education programs. The following general guidelines are recommended

as the means by which the primary training institutions should monitor and control this practice:

1. The hospital governing board or executive committee of the faculty having responsibility for medical standards in the educational setting, should administer the authority to approve or disapprove "moonlighting" in the individual case. This authority may be delegated to the service chief or other individual who controls the content and quality of each training program.

2. In evaluating the content and quality of the training program for each house officer, consideration should be given to the following:

   a. The capacity of the house officer to fulfill his educational objectives while, at the same time, pursuing additional work opportunities for income;

   b. The nature of the work opportunity, including its educational value;

   c. The needs of the community; and

   d. The financial need of the individual.

3. "Moonlighting" by incumbents of internships and residencies approved by the Liaison Committee on Graduate Medical Education, may be permitted only if those activities are reviewed and approved by the person(s) responsible for the individual's graduate training program. House officers should be informed of the substance of this provision prior to appointment.

4. The LCGME should take the necessary steps in its process of approval of graduate medical education programs to assure compliance with the above guidelines.

The new general requirements of the essentials of accredited residencies will require that hospitals and/or programs provide residents with a written statement on practice privileges and other activities permitted outside the educational program. Teaching hospital administrators, program directors and faculty will have to review their policies on these matters and come to positions consistent with maintaining the educational quality of their programs. The fact that Medicare permits residents to be reimbursed on a fee for service basis if they provide physicians' services to beneficiaries outside of their educational activities need not compel institutions to permit "moonlighting" either within their facilities or elsewhere. Although these changes in reimbursement policy may increase the pressures from residents to augment their stipends by after-hours work, policies of teaching hospitals must be based on preserving the quality of their educational program and the residents' educational developments.

B. Services Furnished by Interns and Residents Outside the Scope of their Training Program. The Medicare program reimburses for medical and surgical services furnished by residents and interns that are not related to the intern's or resident's training program and that are performed in an outpatient department or emergency room of a hospital. Such services may be covered as "physicians" services, reimbursable on a reasonable charge basis, but only where all of the following criteria are met:

1. the services are identifiable physicians' services, the nature of which requires performance by a physician in person and which contributes to the diagnosis or treatment of the patient's condition; and

2. the intern or resident is fully licensed as a physician for purposes of performing the services; and

3. the services are performed under the terms of a written contract or agreement and can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns or residents.

The Medicare carrier is expected to review the contracts/agreements for such services to assure compliance with the above criteria.

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