ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
ANNUAL BUSINESS MEETING
Monday, November 8, 1982
2:00 pm - 5:00 pm
Georgetown East & West
Washington Hilton Hotel
Washington, D.C.

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
SPRING BUSINESS MEETING

SESSION I
Sunday, March 28, 1982
5:30 pm - 7:00 pm
Club Conference
Kiawah Island Inn
Charleston, South Carolina

MINUTES

I. Welcome and Overview of the Meeting

Dr. Luginbuhl opened the meeting with an overview of the next few days and extended a special welcome to the new deans in attendance. He explained that Astronaut Senator Harrison Schmitt canceled his presentation to the deans in order to attend the space shuttle's arrival in New Mexico.

Dr. Luginbuhl then introduced the special guests present: Distinguished Service Members Dr. Crispell, Dr. Grulee, Dr. Mayer and Dr. Rich; Canadian Deans Dr. Murray, and Dr. Gauthier; and officers of the AAMC, Dr. Rabkin, COTH Chairman and Dr. Oliver, AAMC Chairman.

II. Report on the Dean's Survey Results

Mr. Keyes reviewed the survey which was undertaken at the request of the Spring Meeting Program Committee. The deans were asked to express their views of the five most important problems or issues that their institutions were currently facing. This was intended to provide the Program Committee with guidance in the design and preparation of this meeting. The overriding problem that most schools were faced with is one of available funds to carry out programs, i.e., funding of research, patient care, student loans, student scholarships, etc. However expressed, the deans were concerned with maintaining quality and adapting to changing needs within the limited and often decreasing resources.

With that as a context, the responses were categorized. The major categories were faculty, finance, patient care and teaching hospital issues, student issues, research, graduate medical education, organizational issues, curriculum and governance. Of greatest concern with respect to faculty was the matter of tenure and the graying of the faculty. Next was the extent of the reliance on faculty practice plans and patient generated income, particularly with respect to its potential for distorting the academic mission of the institution. The general theme with respect to financing related to the reduction of public funds, state funds, and federal funds in all areas but especially with regard to the adequacy of reimbursement for patient services. Nine

institutions indicated major capital needs as an important issue. While there were a variety of manifestations of the financing issue, the funding of teaching costs and the teaching hospital functioning in a competitive environment was the number one unifying theme. Student issues generally centered around the problem of rising tuition, declining student aid funds and the impact that will have on the socio-economic characteristics of each student body. Research issues were exclusively centered on the prospects for future funding while governance issues were most often those associated with the internal problems of allocation of overhead.

Mr. Keyes concluded his report with a review of what the deans felt the role of the AAMC should be in dealing with these issues. Most emphasized the view that the AAMC should continue to provide forums for discussion, sharing of ideas, experience and data.

III. Report of the Chairman of the Assembly

Dr. Oliver reported on his six week sabbatical at the AAMC. The main area of emphasis was in the legislative arena with the objective of helping the Association achieve the two highest priorities that had been developed last year and which were reconfirmed at the Officer's Retreat; the stability of research and research training, and financial aid for students.

He explained that he had met with virtually every key staff member on both the minority and majority sides of Congress dealing with these issues. With respect to the loan program, without exception on both sides of the House, the grassroots activities have informed the Congress of the breadth and intensity of our concerns. While the outcome is uncertain , it is possible to hope that GSL will be available to professional students and will be funded at close to current levels. Dr. Oliver urged that AAMC and its members continue to keep the heat on the Congress in this matter.

Finally, Dr. Oliver reported that with respect to research and research training, the amount of money allotted for new research programs, the ROIs, and the competing programs, was down 36 million dollars. The Administration's proposal that indirect costs be paid at only 90% of negotiated value is intolerable both to the medical schools and to the universities. The land grant colleges, and particularly the AAU have forcefully urged the administration to reverse stand. Dr. Oliver urged the Deans to speak to their Congressional delegation of the importance of the stability of research funding.

IV. Legislative Agenda

Dr. Cooper gave a brief overview of the legislative scene and explained that the major emphasis in the Congress and the Adminstration would be on the national economy and on the federal budget. Last year the Reagan administration enjoyed a remarkable success when the Congress bought his recommendations for the budget

almost lock, stock, and barrel. The victories achieved by the administration, although not uncontested, were solid, and undiluted expressions of the President's campaign promises for cuts in federal spending, increase in defense allocation, a return of certain programs to the states, and a tax cut. They were sold as part of a master plan that would reduce the level of federal consumption and lead to new economic growth in this country with a reduction in the deficit. It appears that the overall plan remains the same for this year as well.

Dr. Cooper pointed out that 1982 is an election year and that this is on the minds of all members of Congress, but particularly the members of the House. With this in mind, he stressed that there would unlikely be any statesmanlike action from either Houses of Congress this year. Thus, between now and adjournment sometime in August, Congress will be considering legislation on the basis of the effect it will have on members chances for survival in the elections.

He further noted that for the medical schools, this economic environment means increased pressure on the programs that have been targeted. What is needed now is a way in which to translate the general public support for medical education, for biomedical research, and for a student body which is broadly representative of the socioeconomic mix of the country into programmatic support. There is still a high regard for the medical institutions and a particular interest in biomedical research.

Dr. Kennedy reported briefly on the President's 1983 budget request. The NIH is up about 3% in current dollars and will certainly be down in real dollars. The research programs in mental health, alcohol and drug abuse did much better, however, they are on a much smaller base. ROIs are down to an estimated 4100 awards, from 4750 this year and 5110 last year, training awards under the President's budget will be about 8900 this year, down from 9700 in the current year, and 10,700 the year before.

Further, Dr. Kennedy reported that there has been a virtual wipeout of student assistance, the National Health Service scholarship program is down, help for freshman student loans will no longer exist, scholarship money has been limited. The VA health care budget is up about 6-1/2%.

Lastly, Dr. Kennedy reviewed with the deans the major items in the legislative scene which include the renewals of the legislation under which the Cancer and Heart Institute, the research programs of alcohol and drug buse, the medical library assistance, and the National Research Service Awards operate. Dr. Oliver was scheduled to testify in the House on behalf of the renewals on the following day.

Dr. Sherman reviewed with the deans the recent issues regarding animal legislation and the proposal for reduction of reimbursement of indirect costs on NIH research grants. There seemed to be a

much higher level of activity at all levels of government by animal welfare groups-- this involved better financing as well as a more aggressive approach. A series of discussion meetings were held between representatives of 12 animal welfare groups and representatives of four research organizations: the National Society for Medical Research, the AAMC, the American Physiological Society, and the American Psychological Association which were particularly interested in issues raised by these animal welfare groups. We agreed, for different reasons, that we did not desire to have ALAC as the accrediting agency for laboratories. They also support the Animal Welfare Act rather than a new piece of legislation since this Act covers research regardless of source of funding. However, we discovered through a new monitoring system set up by the National Society, that bills were introduced in seven different states, and more are expected, either this year or next, which would greatly restrict the availability of animals, if not the use of animals in research.

Dr. Sherman further commented about the indirect cost proposals at NIH. This proposal was a real sleeper and was not learned about until the time of the availability of the Budget Justification Book. It turned out there had been relatively little discussion within the NIH about this proposal and no discussion with anybody on the outside. There has been no response from Secretary Schweiker to the AAMC's position other than the setting up of a meeting in April involving primarily the university presidents to discuss the issue. It appears that our approach, collectively, will be to seek not only some additional money, but also to request a redistribution of the present sums in the President's budget.

Finally, Dr. Knapp commented on the status of the teaching hospitals with respect to their financial status. Net revenue is up substantially over what it was three, four, or five years ago for hopsitals in general. While this is true for a large majority of the hospitals, there are a fair number that are facing severe financial difficulties.

Dr. Knapp pointed out to the deans that the 350 nonfederal members still provide 47% of the charity care in the country and have about 35% of the bad debts. A major issue for COTH has been an attempt to pay at the rate of 98% of the medicare audited reimbursement rate. While it appears this proposal is dead, there will be an effort to make a cut. The Senate Finance Committee is looking to increase the scope of the current ceiling on Medicare reimbursement, which is on routine service costs. On the Medicaid side, the proposal is to take a 3% reduction in the optional service in the medically indigent coverage part of the program. It is our judgement that there may be more success in fighting off the Medicaid cuts than there will be with the Medicare cuts.

In concluding, Dr. Knapp noted two other issues currently engaging our attention--efforts to limit tax exempt financing for capital projects and the problem for some institutions with the reimbursement rate for chronic renal dialysis. These subjects will be discussed much further in the months ahead.

SESSION II
Wednesday, March 31, 1982
8:30 am - 12:00 noon
Club Conference
Kiawah Island Inn
Charleston, South Carolina

V. Consideration of Minutes

The minutes of the November 2, 1981 Annual Business Meeting held at the Washington Hilton Hotel were approved as submitted.

VI. Discussion Items

A. Strategies for the Future - AAMC Work Plan

Dr. Cooper explained that the Work Plan had been under development for some time and served as the subject for the AAMC Officer's Retreat in December. From discussions at the Retreat, the staff has tried to capture what the Association is doing and what the officers felt it should be doing.

Although it is a lengthy Work Plan, Dr. Cooper explained it is one in which many of the subject areas are already being addressed and should be continued. He noted that there are some new areas which the Association feels are important given the changing environment. The Association staff is now in the process of reducing the Work Plan to an actual operational plan to carry out some of the tasks which have been identified with the various bodies of the Association.

Finally, Dr. Cooper noted that the Administrative Board would be asked to review a few of these areas for particular focus at their upcoming meetings this year, i.e., a discussion on the accreditation process, a review of how policy is established and effected in the distribution of residencies, specifically, in relation to sub-specialty training, and the active programs of continuing medical education.

B. National Biomedical Research Month

Dr. Sherman provided both a status report, and a request for advice as far as the future because of the rapidly approaching deadline to proceed. A tentative steering committee has been identified which will be called upon if the decision is to proceed. From the COD, Dr. Janeway and Dr. M. R. Schwarz have agreed to serve on that committee.

He reported that letters have been sent to approximately one hundred professional societies and voluntary health organizations in an exploratory move to see whether or not there is, even on a

tentative basis, a broad base of support for such an activity. It was stressed that unless an effort was undertaken well, with a broad base of sponsoring support, intellectual as well as financial, it could be a disaster and therefore, should not be attempted at all by any organization or any group of organizations.

Secondly, exploration has begun with a few foundations as to the possibility of some front-end money in the amount of $10,000 - $15,000. The purpose of these funds are to develop a strategy package which would explain how such an effort would be based and undertaken. The cost of the entire endeavor has been estimated at approximately a quarter of a million dollars.

Finally, Dr. Sherman reported that the Association has had a series of discussions with public relations firms as to the feasibility of such a project and what their involvement would cost. We have concluded the AAMC does not have the expertise nor the resources to undertake such an effort and do it well.

Part of the design of the project has been the assumption that unless an effort of this sort is combined at the national and local levels, with member institutions participating under a national umbrella, it would not succeed. Two questions were raised for COD consideration--(1) what is the potential for institutional commitments--recognizing that it is not possible at this time to specify precisely what this would involve, and (2) what priority does it have, both for the Association and for the individual institutions?

Dr. Janeway expressed his view that it would be appropriate to take the high road in this instance and make an effort at least to explain to the world what it is we're really all about.

After discussion among the members of the Council, a resolution was proposed that the COD endorse, in principle, the concept of a National Biomedical Research Month, provided sufficient funds could be obtained.

On motion, seconded and carried, the Council of Deans voted to adopt that motion.

C. Medical Student Financial Assistance Questionnaire: Preliminary Report

Dr. Oliver briefly reported on this at the Sunday night meeting of the COD. It was stressed that we must convey our belief that students have a legitimate responsibility to pay for their education. However, if medical education is to be available for the full spectrum of our society, there must be resources available for them to do that. Dependency on the Guaranteed Student Loans provide an example of this need: 71% of borrowing in 1980-81 is from this source. This point was emphasized in the AAMC's testimony to Congress. One of the most important tasks to be faced by the AAMC is to obtain reasonable loan resources to enable people

across the full socioeconomic spectrum to have access to medical education. The Association is trying to point out that trying to put a cap on the federal credit budget so as to limit GSL funds is not really rational because this item does not represent in truth a federal obligation of any significance. Dr. Cooper reported that with Sallie Mae getting into the HEAL program, there is a far greater confidence that HEAL money will be available in the next several years. The deans will be informed of any signficant changes in the loan situation.

Dr. Cooper reported that he had spoken with Dan Whiteside who revealed that OMB had suggested that he let the loan level rise to meet the need of the HEAL program. This is possible in part because the federal credit budget was never acted upon and it is not law. What governs this is the level that the appropriating committee sets.

Dr. Cooper was also asked by Dr. Whiteside to raise with the deans the need to act on the notification they received from the the Inspector General regarding delinquencies and loan repayments by members of their faculties. Apparently the Inspector General has gone into the records and has identified delinquent loans that have not been repaid by members of our faculties.

D. Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management

This report calls for the application of new information transfer and handling technologies to the academic information resources base. It does not deal with the structure or organization of hospital or administration--administrative information systems. But what it does deal with is the core of what scholarly institutions are all about.

It recommends, 1) moving the academic health science center libraries into an electronic mode; 2) expanding significantly the networking of libraries--both intramurally with other data bases within institutions and extramurally with other libraries and other data bases; 3) establishment of several demonstration programs around the country in order that academic administrators librarians, faculty and students can really see what in fact can be accomplished by applying already existing technologies to that knowledge base; and 4) setting up of training programs for librarians to get them up to speed in this area and taking the necessary steps to get the faculty and students computer literate.

Lastly, the report has been submitted in draft form to the National Library of Medicine by the AAMC. It should be in relatively final form within the next month and hopefully by the late summer or early fall, it will be published as a supplement to the Journal of Medical Education. Mr.Keyes and Dr. Cooper will be presenting this Report to the Board of Regents of the NLM in May. It is anticipated that the report will form the basis for some of the new directions for the NLA.

E. The General Professsional Education of the Physician and College Preparation for Medicine

Dr. Swanson provided a brief progress report on the status of the AAMC Study on the General Professional Education of the Physician.

F. Request of the Society of Medical College Directors of Continuing Medical Education

Dr. Luginbuhl briefly summarized the developing relationship of the SMCDCME and the AAMC and its request for a definition of this relationship.

The Council of Deans, by unanimous vote, adopted a resolution at its 1982 Spring Meeting to 1) oppose the concept of separate accreditation or separate standards of accreditation from those of the Accreditation Council for Continuing Medical Education; and 2) to affirm the Council's view that the proper mechanism for Directors of CME to relate to the AAMC is through their membership and participation in the Group on Medical Education.

G. Request for New Data Collecting and Reporting Activity

Dr. Henry reported that after reviewing the LCME data base for preparation of his institution's self-study and looking at the annual financial questionnaire, it became apparent that the information on the unrestricted funds was limited to lump sum figures. It became clear in talking with individuals at other schools that there is an increasing interest in tracking the sources of funding to individual departments.

His objective was to acquire comparative data across institutions regarding the funding of individual departments. Thus, by listing the individual departments rather than the school as a whole, unrestricted funds, that is, tuition or public institution and state dollars, endowment earnings, and unrestricted gifts could be looked at in terms of their distribution to departments.

After discussing this at the Council of Southern Deans there was a decision that that group would cooperate with Dr. Henry in a pilot venture to collect data in a format that would give us more specific information in termss of sources of funding for the individual department programs which could be looked at in terms of a comparative basis.

H. VA Faculty Retirement: A Proposal

In the discussion following Dr. Custis's presentation, Dr. Fogel described his institution's efforts to acquire IRS acquiescence in a proposal that the medical school supplement the retirement benefits of VA based faculty members without having the supplemnt being regarded as income taxable on a current basiss to the faculty member. He had concluded that this would require legislation. He was interested in exploring whether the VA and/or the AAMC would

endorse and support such a legislative initiative. The discussion disclosed that this was generally regarded as an unfavorable time to seek such legislation. There was little or no support for establishing this as an AAMC priority.

VII. New Business

A. Report on the Last Meeting of the National Board

Dr. Janeway sumarized the last meeting of the National Board with regard to the Flex I/Flex II concept of the Federated State Medical Board of licensure. The Executive Board took an action in reponse to a letter from the FSMB defining its interpretation of the Flex I/Flex II concept. The NBME Executive Board did not endorse this interpretation and it persuaded the Federation to change the language to make it more technically correct.

It was noted that Dr. Mayer had introduced a motion which in effect was a cease and desist order directing the NBME to stop its planning to implement the FSMB concept. Although this motion did not pass, it clearly gained the attention of the entire Board and of the representatives of the FSMB to the National Board. Subsequently, two resolutionss were passed. The first reaffirmed the National Board's commitment to the continuation of the present national Board certification program (as the nature of education and evaluation in medicine evolves, the NBMS has the responsibility to consider modifications in its requirements for certification) The second National Board of Medical Examiners acknowledged, but did not support that the Federation of the State Medical Boards has the goal of achieving uniform examination requirements for licensure.

Dr. Janeway concluded that the Federation is not backing away from their concept of adopting Flex I/Flex II when it becomes available. He explained his view that in an attitudinal sense, there has been some progress in getting the federation to recognize that the AAMC and all of the members of the Council of Medical Affairs are opposed to the concept of Flex I/Flex II in isolation.

Finally, Dr. Janeway emphasized that the Federation has changed its concept somewhat in order to try and accommodate the academic community; Flex I is now proposed to be given after the receipt of the MD in June, and also be be offered in December of that year, then the following June. Passage of Flex I would be a requirement not to enter the first year of graduation medical education, but to enter the second year. The Federation would also propose that states have a local option to administer Flex I and Flex II simultaneously. This apparently is to avoid the potential thrust to licensure by specialty that is sometimes inputed to the Flex II concept.

VIII. Adjournment

The meeting was adjourned at 12:00 noon.

ELECTION OF INSTITUTIONAL MEMBERS

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

Full Institutional Membership

East Tennessee State University
College of Medicine

Oral Roberts University
School of Medicine

Provisional Institutional Membership

Mercer 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 and Provisional Institutional Membership in the AAMC.

RECOMMENDATION

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

ELECTION OF DISTINGUISHED SERVICE MEMBER

At its June 24 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 John W. Eckstein, M.D., Chairman, William B. Deal, M.D. and M. Roy Schwarz, M.D., met and presented its recommendation at the September 9 Board meeting. The following individuals were submitted for consideration for election to Distinguished Service Membership in the AAMC:

John A. Gronvall

Julius R. Krevans

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 T. Butler, Chairman
Ransom J. Arthur
John A. Gronvall
Alton I. Sutnick
James Eckenhoff

The committee solicited the membership for recommendations of persons to fill the available positions by memorandum dated May 7, 1982. The returned Advisory Ballots were tabulated and the results distributed to each committee. The committee met by telephone conference call on June 3, 1982. Dr. Butler's letter report (dated June 22, 1982) of the committee's recommended slate of officers follows.

Baylor College of Medicine
OFFICE OF THE PRESIDENT • 713 790-4400

June 22, 1982

William H. Luginbuhl, M.D.
Dean
University of Vermont College of Medicine
Given Building
Burlington, Vermont 05405

Dear Bill:

This letter constitutes my report as Chairman of the Council of Deans' Nominating Committee to you as Chairman of the Council of Deans. The Committee met at 2:30 p.m., EDT, on June 3, 1982, by telephone conference call. At that time, we had available to us the tallies of the advisory ballots submitted by members of the Counil.

The Nominating Committee was cognizant of the COD rules and regulations, as well as the AAMC bylaws. For the offices to be filled by vote of the Council of Deans, your Nominating Committee proposes the following slate:

Chairman-Elect of the Council of Deans
Edward J. Stemmler, M.D.
Dean
University of Pennsylvania School of Medicine

Members-at-Large of the Council of Deans
Arnold L. Brown, M.D.
Dean
University of Wisconsin Medical School

D. Kay Clawson, M.D.
Dean
University of Kentucky College of Medicine

William B. Deal, M.D.
Dean
University of Florida College of Medicine

Other offices are filled by election of the Assembly. A slate will be proposed for the Assembly's consideration by the AAMC Nominating Committee of which I am a member. The Committee that I chair has been asked to submit names in the form of recommendations to that Committee.

TEXAS MEDICAL CENTER • HOUSTON, TEXAS 77030

On the basis of our deliberations, our committee will recommend as follows:

Council of Deans Representatives to the Executive Council
Fairfield Goodale, M.D.
Dean
Medical College of Georgia School of Medicine

Louis J. Kettel, M.D.
Dean
University of Arizona College of Medicine

Chairman-Elect of the Assembly
Robert M. Heyssel, M.D.
Executive Vice President & Director
The Johns Hopkins Hospital

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 as Chairman of this Committee.

Sincerely yours,

William T. Butler, M.D.
President
Baylor College of Medicine

WTB:hd

xc: Members of the Nominating Committee
Ransom J. Arthur, M.D., University of Oregon School of Medicine
John A. Gronvall, M.D., University of Michigan School of Medicine
Alton I. Sutnick, M.D., Medical College of Pennsylvania
James Eckenhoff, M.D., Northwestern University Medical School
Joseph A. Keyes, J.D.

EVALUATION OF THE PERFORMANCE OF CLINICAL CLERKS

In 1978 the AAMC undertook a project to describe the problems of evaluation of medical student performance in the clinical setting. Through the auspices of the chairmens' organizations of medicine, surgery, family practice, pediatrics, psychiatry, and obstetrics/gynecology, departmental chairmen were asked to identify the member of their department who had primary responsibility for the evaluation of junior medical student clerks. The response was gratifying and the names of over 500 faculty members were provided. These individuals were contacted and asked to submit the evaluation instruments used in their clerkship. More importantly, they were asked to describe their personal views of the problems that arise in the evaluation of the performance of clinical clerks. The following summary of the project's findings and plans for future efforts in this area will be discussed by Xenia Tonesk, Ph.D., Program Director, Personal Characteristics and Skills Assessment, of the Association.

The importance of pursuing improvement in the evaluation of student performance is highlighted by the response of 403 clinical faculty members to the question, "Do evaluation methods in the organization of evaluation data from the clerkships ensure that deficiencies in students' knowledge, skills, and attitudes are identified?" -Three hundrend and twenty two responded "no" to this question in the spring of 1982.

A discussion draft

THE EVALUATION OF CLERKS: PERCEPTIONS OF CLINICAL FACULTY

A Summary of the Issues
and
Proposed Actions

Xenia Tonesk, Ph.D.
Director, Clinical Evaluation Project

Association of American Medical Colleges
Department of Academic Affairs
Division of Educational Measurement and Research
September, 1982

INTRODUCTION

The evaluation of medical students' performance in their undergraduate clinical years is perhaps the most important responsibility of the faculty. The clinical setting is where students are expected to develop fundamental clinical skills and to begin to apply their knowledge of biomedical science. Students who are not performing well must be identified, steps must be taken to assist them, and, if necessary, some students must be dismissed. This requires that information from a variety of sites and sources be aggregated, weighed and acted upon. Clinical faculty are concerned that they are not effectively accomplishing this responsibility.

In 1978, the Association of American Medical Colleges, through the Clinical Evaluation Project, began to study the problems of the evaluation process from the perspective of clinical faculty. During the course of the project it became clear that there are two distinct sets of factors that exacerbate the situation as it now exists.

There are external factors over which faculty do not have direct or immediate control:

- The reward system encourages clinical faculty as generators of income for institutional support rather than as teachers and evaluators.
- There is a greater demand for faculty involvement in graduate medical education resulting from the expansion of residency training and closer affiliations between medical schools and teaching hospitals. (In 1982, 92% of fourth-year medical school seniors indicated they plan to obtain specialty certification.)
- Greater numbers of faculty and clinical training sites have been pressed into service of educating clerks without appropriate adjustments to the education system, for example: better coordination of the students' clinical experiences at both the departmental and institutional levels; more precise delineation of what faculty are to teach and evaluate; the implementation at the departmental level of institutional guidelines for dealing with problem students.

- The emergence of student "rights" has resulted in faculty's reluctance to record negative evaluations due to fear of legal reprisal. This hesitancy persists in spite of the fact that in numerous instances courts have upheld faculty judgments.

While mindful of the importance of these general institutional considerations, the AAMC study concentrated on identifying and addressing those factors which are more directly controlled by faculty. The purpose of this report* is to summarize the basic problems identified by the faculty which may be readily remedied and to outline an approach for resolving the problems. The conclusions presented are drawn from two sources:

- Written statements received from 519 clinical services in response to an AAMC inquiry regarding the obstacles to valid, objective and efficient evaluation of clerks. These include 81 responses from internal medicine, 89 from obstetrics-gynecology, 98 from pediatrics, 89 from psychiatry, 103 from surgery and 59 from family medicine.

- Information gathered by AAMC staff from site visits to 14 medical schools.

*A comprehensive background document containing detailed information about the project and the findings is available; inquiries should be directed to Dr. Tonesk at the AAMC.

FINDINGS

Faculty place too much emphasis on the instruments and methods of evaluation. The primary preoccupation seems to be HOW to evaluate, and much effort is spent scrutinizing evaluation forms, behavioral checklists, and the formats of written and oral examinations. Because of pressures of increased workload and accountability, faculty expect and would welcome the development of the reliable and valid instrument or set of instruments that would resolve their major concerns with evaluation. This expectation is encouraged by evaluation "experts", psychometricians and behavioral scientists who have consistently labeled faculty judgments as unreliable and "soft" and have urged faculty to focus on methods yielding "objective" assessments. Thus, evaluation discussions often include the pros and cons of different numbers of points on rating scales, the merits of an honors/pass/fail system versus letter grades, or whether an oral examination can be made objective. This is misdirected expenditure of effort.

If the situation is to change, if faculty are to assume and execute successfully their appropriate role in the evaluation process, two things must occur:

- Faculty must acknowledge that the primary responsibility for obtaining meaningful evaluations rests with them and that psychometric solutions can not be viewed as substituting for but only as supplementing their judgments.
- Faculty must shift and broaden the perspective from which they view evaluation i.e., the evaluation task must be seen in terms of a system in which many factors determine the optimal evaluation framework for an institution. In other words, faculty must consider WHO evaluates, and WHOM, WHY, WHERE and WHAT they are evaluating prior to considering HOW to evaluate.

WHO - The Evaluators

All persons with access to evaluative information who can make valuable contributions to the evaluation process should be appropriately identified,

used, and integrated into the system.

- Persons who have first-hand information about clerks should be identified and afforded the opportunity to transmit it formally. For example, junior residents and nurses see behind-the-scenes behaviors not usually observed by senior faculty.

- Persons should not be asked for information that they cannot provide. For example, when attendings serve as the sole evaluators of clerks, they may be recording judgments without the requisite valid information.

- Different evaluation perspectives must be recognized and handled appropriately. The data suggest three kinds:

  - o There are important specialty differences in the definition of characteristics to be assessed. For example, the physician-patient relationship has different connotations for surgery, pediatrics, and psychiatry.

  - o Evaluators have different expectations with respect to the roles clerks are to assume on a service. On some services, clerks are encouraged to be active participants; on others, passive observers. On some services, adequate history-taking and physical exam skills are assumed; on others, many hours sometimes involving videotaping are spent in teaching such skills.

  - o Each evaluator has a personal perspective that enters into any assessment. There are some superb teacher-clinicians who cannot bring themselves to fail anyone; some engrossed researchers who reward knowledge in their specific areas; some junior residents who feel more insecure than the clerks they evaluate, etc.

WHOM - The Clerks

In order to be effective and efficient, the evaluation process has to be tailored to different categories of students. Faculty must have confidence in their subjective categorizations of students as a valid first step in the evaluation process and must follow through with the appropriate course of action. Through their unstandardized encounters with students over the years, faculty have accumulated an experiential data base that cannot be replaced by information gathered through existing standardized evaluation instruments.

The collective judgments of faculty permit a ready classification of students into three major categories: superior, adequate and failing.

What occurs is a simple sorting and consensus process: conspicuous students at both extremes make strong and quick impressions on everyone; by default, the rest of the clerks fall into the middle. Conspicuous students are conspicuous precisely because they generate unsolicited information; for the rest, there has to be an active effort to obtain it.

- Faculty identify reliably and handle well the superior student. The evaluation task is one of documenting illustrative specifics, indicating the overall consensus, rewarding, reinforcing and sending the students on to the next opportunity to excel.

- Faculty identify reliably but do not handle well the failing student. The evaluation task is to document the weaknesses, to make explicit the requirements for satisfactory performance, and to specify the criteria by which judgments will be made. If such remediation efforts fail, care must be taken to achieve consensus on dismissals and to accord to the student fair procedures of redress. Fear of legal reprisals undermines the evaluation process with this group.

- Faculty do not identify reliably nor handle well three quite different sub-groups within the heterogenous catch-all category of adequate. Students are rated adequate because: a) they are indeed average and "unremarkable"; b) no one knows them well enough to rate them any other way; or c) the benefit of the doubt invites a positive tilt and allows for inclusion as adequate students who are marginal. Faculty must discriminate among the three sub-groups, verify their conclusions and follow clearly defined steps in each case in order to arrive at a deliberate judgment.

Figure 1 summarizes the different approaches to be used with the categories of students.

WHY - The Purpose

Faculty must be aware of their dual role as evaluators in as much as evaluation serves two distinct purposes: competency development and competency assessment.

- Competency development mandates periodic evaluations with feedback to the student as an essential element of the evaluation task. Faculty must know the clerks well enough to identify and highlight strengths and weaknesses in order to pinpoint directions for maximum growth.

- Competency assessment requires the application of specific evaluation standards for acceptable performance. Feedback is an incidental matter.

WHERE - The Setting

Faculty must not lose sight of the influence of the clinical setting on the evaluation task. For example,

- The ambulatory care setting provides little opportunity for observing clerks with patients over a period of time.
- The busy ward permits only the junior resident to really know the clerk;
- A particular clinical service may provide little educational guidance but much hands-on experience.

WHAT and HOW - The Content and Methods

It is important to recognize that method of evaluation is inextricably linked with content of evaluation. Accordingly, faculty must affirm their role both in the definition of content and in the selection of methods.

There are different classes* of content, each with important implications for method.

- Cumulative characteristics are assumed to be augmented at each phase of medical education (e.g., fund of knowledge, technical skills) and are most amenable to evaluation by "objective" assessment instruments. In designing a system of evaluation for such qualities, the task is not so much one of developing instrumentation, but of defining explicitly what is to be assessed, gauging meaningfully the level at which a particular quality is to be manifested at a given stage of the education process, and specifying the rate of expected growth and improvement. The instrumentation need not be reinvented at each institution but merely adapted to the particular clinical setting, department, or medical school.
- Enduring characteristics affect clinical performance but are more difficult to modify in the routine course of the educational process (e.g., sensitivity, ethical behavior, compulsivity). Instrumentation for the assessment of enduring qualities should of necessity be quite different from that applied to cumulative characteristics. Often there are no specific checklists of observable reference points for quantification. What is needed are convenient devices to aid faculty in organizing and communicating their clinical impressions in the most informative way.

*These categories were originally developed by the author for the AAMC position paper "External Examinations for the Evaluation of Medical Education Achievement and for Licensure," (Supplement to the Journal of Medical Education, November, 1981.)

- Latent (inferred) characteristics (e.g., supervisory ability, teaching ability, independent decision-making) require faculty to assess the potential of clerks on dimensions for which little current data in terms of actual behaviors are available at the time. Faculty judgments recorded on communicative evaluation forms are the most appropriate vehicle for evaluation. Even more than in the case of enduring characteristics, any elaborate quantification of latent qualities is apt to belie the tentative basis of faculty judgments.

If content is to be viewed from a progressive, developmental, longitudinal perspective, the faculty must devise effective and acceptable ways of implementing in the evaluation system a cumulative evaluation record for each student so that action judgments are based on information that expands along with the student's progress in the program.

GENERAL CONCLUSIONS AND RECOMMENDATIONS

Because many interrelated factors comprise the evaluation of students in clinical settings, the variety of information gained as students progress through their clerkships must be integrated through an institutional system that accommodates formal and informal sources of data, different categories of students, different purposes, varying clinical settings, and diverse content. Frequently debated problems of validity and reliability take on a broader meaning when viewed from a systems perspective i.e., the focus becomes one of the validity and reliability of a system rather than that of an instrument. For example, a valid, reliable technique is useless if its results are adulterated and confounded by pooling them with questionable information from a biased source. Likewise, valid information is useless if it is not systematically incorporated into a student's record. Conversely, segmented and isolated information, while it may be valid and reliable is not very meaningful unless placed in context of the totality. The system of evaluation, as a sum, is greater than its parts and should effectively yield more than a simple aggregation of individual sources of information.

An effective evaluation system requires more than the assurance of probity of information. Faculty and students have to share an understanding of the different purposes evaluation serves. The evaluation efforts have to be proportionate to the benefits derived from the results, so that the system is not burdened with unproductive routine. This means that the process may not be uniform across students. The flow of information has to be timely and targeted, allowing for different pathways depending on level, content, and decision alternatives available.

Because of institutional diversity, no two institutions will have identical optimal systems of evaluation. However, the methodology of arriving

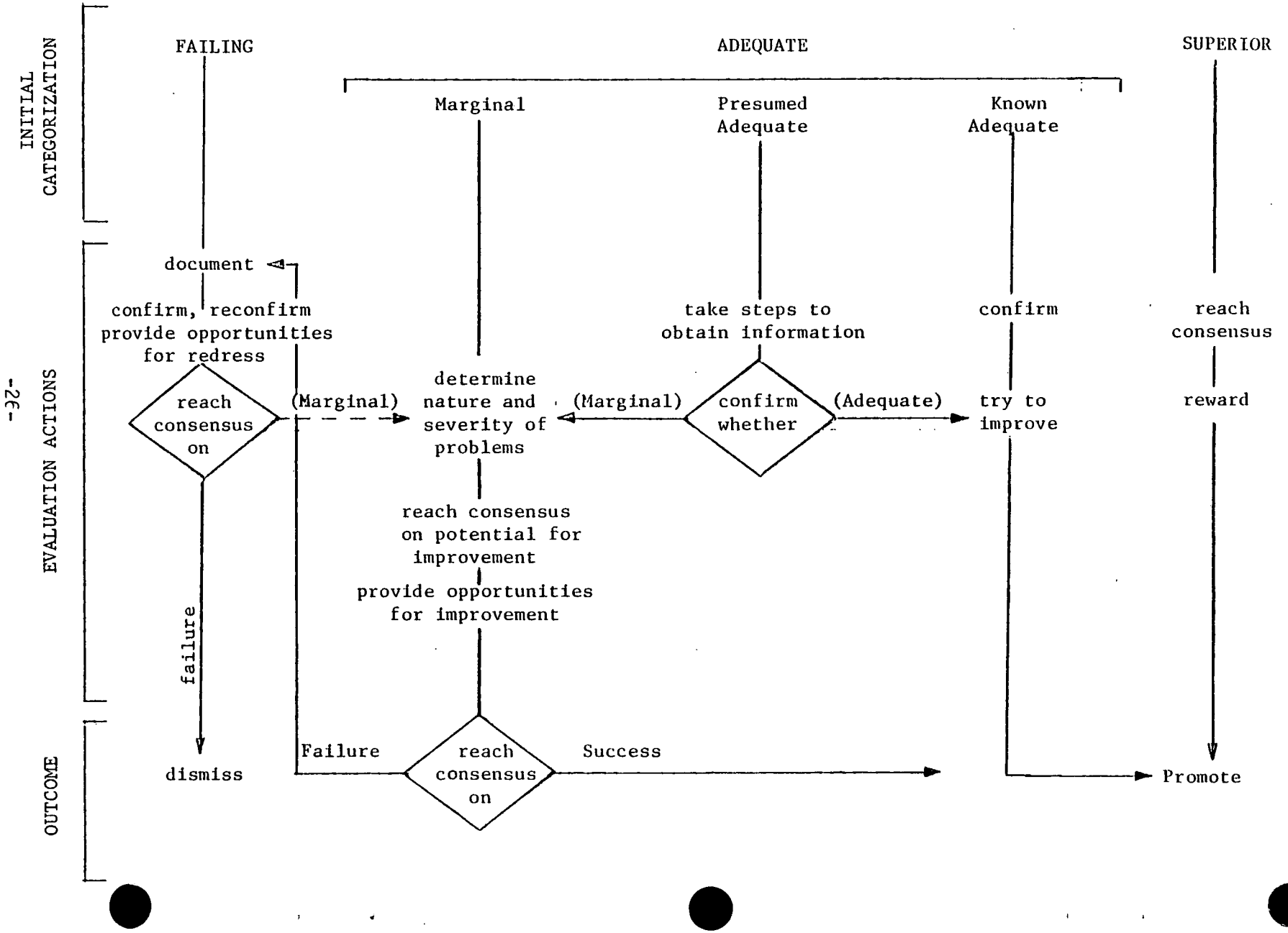
at a delineation of institutional requirements might well be the same or similar.

In order to be able to identify the optimal systems of evaluation for interested medical schools, the AAMC has outlined the following steps:

- The AAMC proposes to develop a set of guidelines of self-study for the diagnostic phase of the institutional evaluation system. Such materials would help schools to examine methodically the various parameters critical for designing the optimal evaluation system.
- The proposed blueprint for self-study will be developed and tested at several institutions of widely varying character.
- A task force will review an inventory of available formal evaluation techniques suitable for particular aspects of evaluation. Once an institution is satisfied through self-study that it has outlined an improved evaluation system, such an evaluation of the state-of-the-art will greatly aid in the implementation of needed improvements.

FIGURE 1

INITIAL CATEGORIZATION OF STUDENTS AND SUBSEQUENT EVALUATION ACTIONS



MANAGEMENT OF ACADEMIC INFORMATION

The nation's capacity for meeting the information needs of the health professionals, a traditional role of the health sciences libraries under the leadership of the National Library of Medicine, is likely to be radically affected by the rapidly evolving electronic information environment. New technologies improve our ability to selectively access information and offer an approach to managing the overload caused by the continuing expansion of knowledge which is so pronounced in the biomedical sciences. We are seeing a shift from paper to electronic means of managing information and the academic community is exhibiting a growing awareness of a need to incorporate new information technologies into the processes of medical education, research, and health care practices.

Under the contract with the National Library of Medicine, the AAMC recently completed a study entitled, Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management. Nina Matheson, M.L., served as principal investigator of the two year study which involved site visits to ten institutions, meetings with many groups of health sciences librarians, an extensive review of the literature, and the analysis of data from several surveys. She was assisted by a nine member advisory committee chaired by William D. Mayer, M.D., President of the Eastern Virginia Medical Authority which concurred in the report's recommendations. Other members of the advisory committee included Louise Darling, Librarian Emeritus, UCLA School of Medicine, Samuel W. Hitt, Director, Health Sciences Library, University of North Carolina School of Medicine, Virginia Holtz, Librarian, Middleton Health Sciences Library, University of Wisconsin Medical School, Donald A.B. Lindberg, M.D., Professor of Pathology and Director, Information Science Group, University of Missouri-Columbia School of Medicine, Thomas H. Meikle, Jr., M.D., Dean, Cornell University Medical College, M. Roy Schwarz, M.D., Dean, University of Colorado School of Medicine, Cheves M. Smythe, M.D., Professor of Medicine, University of Texas Medical School at Houston, and Marjorie P. Wilson, M.D., Senior Associate Dean, University of Maryland School of Medicine. The final report was presented to the Board of Regents of the National Library of Medicine on May 20, 1982 by John A. D. Cooper, M.D., Project Director. The Executive Council endorsed the Report's recommendations at its June meeting. It will be published as a supplement to the Journal of Medical Education in October 1982.

The Report directs recommendations to three main groups. It suggests that individual institutions begin immediately to take three steps. They should equip their libraries to function in a technologically sophisticated information environment. They should identify leadership in their organizations to develop institutional strategies for integrating computer-based knowledge management in the education and practice processes, and they should begin to introduce the principles of information handling and the future prospect of integrated network systems in the medical enterprise to a broad spectrum of members of the academic medical center community.

The Report recommends that professional associations assist institutions to achieve the long-range goals of linking institutional integrated information network systems. Associations could help bring together the resources and the interests that could develop linkages between institutions, hospitals, and individuals to make information access and use efficient. They could draw together the many public and private and federal interests into a coalition to support a large-scale evolutionary change in academic information management.

The Report also calls on industry and the private sector to become more familiar with the unique nature of the academic medical center environment and to help build better systems for the management of the knowledge base that is vital to quality medical education and care. Finally, the report recommends that a national agency should spearhead this innovation process. The most appropriate agency to carry out this role is the National Library of Medicine which has already established its credentials as a leader in developing innovations to make more effective use of biomedical information.

ACADEMIC INFORMATION IN THE ACADEMIC HEALTH SCIENCES CENTER: ROLES FOR THE LIBRARY IN INFORMATION MANAGEMENT

Synopsis

When this study was conceived nearly three years ago, the basic assumptions were these:

1. Electronic information handling is firmly established in society.

2. The growth rate of new information will not decrease. In fact, it is accelerating because of the use of computers in research.

3. Applications of telecommunications technologies are bound to affect:

   A. Professions like medicine that are information intensive;
   B. Major information control systems like libraries

4. Methods must be found for more efficient and effective storage, retrieval, and distribution of medical knowledge. It is impractical to continue to depend as heavily as we do on human memories to provide a quality knowledge base for teaching, research, or patient care.

5. Senior medical center decision makers need a perspective on the environment and on emerging trends. They need information to handle the questions of:

   A. Where are we today?
   B. Where do we need to go and why?
   C. How can we get there?
   D. What will it cost?
   E. What do we have to do? What are the first steps? Who should do what?

What was found through research in the literature, through site visits, and through surveys is this:

1. There is probably an irreversible trend towards full computerization of the world information base. The trend is well advanced. Japan, for example, has set this as one of its national goals for its fifth generation computer development over the next ten years.

2. Technology adoption occurs in three stages. The first is conversion from the old to the newer technologies. The second is innovation: doing what was never done before. The third is transformation: we do things entirely differently. Academic medical centers are barely into the first conversion stage of only one type of information

transfer. We use computers for operational, administrative and research data collection management. Very little attention is given to academic information, to the recorded world knowledge base. The infusion of new knowledge is essential to improving operations, for quality education, and for conducting research. Unfortunately, little effort is made to increase the effectiveness of academic information transfer.

3. The knowledge base is being converted by publishers at the input stage, the front end of the information chain. For example, the AMA and the American Chemical Society among others, are rapidly converting their paper products to electronic form. Before very long, only institutions with sophisticated academic information control systems, and that translates into sophisticated library systems, will be in a position to exploit the inherent efficiencies and economies of electronic information systems.

4. The conversion of traditional organizational and academic information is leading to two 2nd stage innovations in information transfer. One of these is clinical decision support systems like CADUCEUS and MYCIN; the other type is online encyclopedic knowledge bases like the NLM prototype hepatitis and human genetics knowledge bases. These innovations were outgrowths of artificial intelligence research. They have now developed to the stage of free-standing systems that will continue to evolve and be refined. They need to be brought into the education and health care processes.

5. Academic medical centers are poorly positioned to operate effectively in an electronics dominated information handling environment. The reason is that they have yet to recognize or adopt three principles that corporations and businesses that are highly information dependent have developed and acted on.

   The first principle is that homogenity of information transfer is essential to effective use of information. Little independent systems that deal with bits of the work of an organization are wasteful and usually counterproductive. They must at least be able to exchange information directly between systems.

   The second principle is that complex organizations need an information policy, a corporate concept of how information will be managed to support the corporate goals. Organizations with interdependent missions for patient care, education, and research, for example, need an integrated information handling system policy.

   The third principle is that the configuration of information systems must fit the corporate organization. For highly

decentralized environments such as medical centers, where collegial relationships are prized, distributed network systems are likely to be the most effective.

6. Academic medical centers are ill prepared for the computer sophisticated students about to emerge from undergraduate programs. The heavy dependence on rote learning in the health sciences is in contrast to other graduate level professional programs that concentrate on concept development and problem solving principles supported by highly developed information support bases.

The report examines this large complex environment from the perspective of academic information handling needs. Since the library is the significant organization in an institution responsible for the storage and management of the recorded world knowledge base, the report concentrates on how libraries can and are likely to change technologically, and how these changes will affect the way faculties, staffs, and students use information in their work.

The changes are positive, badly needed, and affordable. The report lays out a blueprint for proceeding in practical ways to adopt telecommunications technologies to meet some important and immediate needs. It shows, through a number of scenarios, how the applications of newer information technologies can benefit the researcher, the student, clinician, and administrator. It spells out the principles on which libraries might operate more effectively. It describes how they might evolve into second stage innovative systems. It suggests how some libraries can lead in the development of integrated institutional networks. Finally, it directs recommendations to three groups that will have to work together to bring about a necessary change in a timely fashion.

Academic medical centers are called upon to take the first steps towards information networks by strengthening the technological capabilities of their libraries. Professional bodies are asked to assist medical centers to strengthen the interactions among education, research, and patient care components through the incorporation of information management technologies. Prototype systems will need to be developed. Finally, public and private agencies are asked to share in the costs of developing and supporting state-of-the-art information technologies to ensure a quality world biomedical information base.

The report concludes that the need for action is immediate and urgent. Even in these times of resource limitations, we must take some first steps and expend a portion of those financial resources to secure a more effective use of our intellectual resources.

This is the fourth in a series of reports developed by the AAMC under NLM sponsorship. Each of the earlier reports has had a concrete impact on advancing the management of information in the biomedical sciences. It is hoped that this report will make a contribution equal to the earlier efforts.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #82-56 October 15, 1982

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals

FROM: John A.D. Cooper, M.D., President

SUBJECT: New Medicare Program Regulations

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) made significant changes in the Medicare program. Because many of these changes are effective with the beginning of the Federal Government's new fiscal year (October 1st), the Health Care Financing Administration has recently published 10 proposed, interim final, or final regulations significantly affecting hospital and/or physician reimbursements. This memorandum summarizes each of the published regulations in enclosure A and provides one copy of each in the reprint from the Commerce Clearing House:

Subject	Regulatory Status	Enclosure Page
Payment for Physician Services Furnished in Institutional Providers of Services (i.e., hospitals)	Proposed rule with no stated effective date Comments received through November 1, 1982	43578
Limitation on Reimbursable Costs and Rate of Hospital Cost Increases (e.g., percentage increase limits for hospitals)	Effective for cost reporting periods beginning on or after October 1, 1982 Comments received through November 29, 1982	43282
Schedule of Limits on Hospital Inpatient Operating Costs (i.e., Section 223 limits for hospitals)	Effective for cost reporting periods beginning on or after October 1, 1982 Comments received through November 29, 1982	43296
Limitation on Reasonable Charges for Services in Hospital Outpatient Settings	Effective October 1, 1982 Accept comments mailed by by November 30, 1982	43610
Assistants at Surgery	Effective October 1, 1982 Accept comments mailed by November 1, 1982	43650
Elimination of Medicare Indirect Subsidy for Private Rooms	Effective October 1, 1983 Accept comments mailed by October 28, 1982	42676

Elimination of Inpatient Routine Nursing Salary Cost Differential	Effective October 1, 1982 Comments received through November 29, 1982	43618
Treatment of Cost of Uncompensated Services Furnished in Fulfillment of a Hill-Burton Free Care Obligation	Retroactive to start of Medicare Program Comments received through November 30, 1982	43656
Schedule of Limits on Home Health Agency Costs Per Unit	Effective for cost reporting periods beginning on or after September 3, 1982 Comments received through November 29, 1982	42904
Schedule of Limits on Skilled Nursing Facility Inpatient Routine Service Costs	Effective for cost reporting periods beginning on or after October 1, 1982 Comments received through November 29, 1982	42894

I urge that you and your staff give these regulations immediate attention. Particular consideration by senior level staff should be given to the first five regulations summarized in enclosure A. For each of these items, an initial statement of AAMC concerns is also contained in enclosure A.

If you have questions on any of the enclosed regulations, please call the staff of the Association's Department of Teaching Hospitals:

Dick Knapp (202) 828-0490
Jim Bentley (202) 828-0493
Joe Isaacs (202) 828-0496
Nancy Seline (202) 828-0496

As you submit letters of comment on the regulations, please send copies to the AAMC, Attention: Department of Teaching Hospitals.

SUMMARY OF MEDICARE REIMBURSEMENT CHANGES
(PREPARED BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES)

PAYMENT FOR PHYSICIAN SERVICES FURNISHED IN INSTITUTIONAL PROVIDERS OF SERVICES

Regulatory Status

1. Proposed Rule
2. Effective Date: not specified
3. Comment Date: through November 1, 1982

Publication

Federal Register of October 1, 1982, pp. 43578-43608

Summary

These proposed regulations revise and modify Medicare rules for physicians' services provided in hospitals. Initially, the regulations separate physicians' services into (1) services provided to individual patients and (2) services provided to the hospital, such as supervision and quality control. Physician services will be considered services for individual patients if they:

-- must be personally furnished for an individual patient by a physician;

-- require performance by a physician, and are not frequently and consistently furnished by nonphysicians; and

-- contribute to the diagnosis and treatment of an individual patient.

Physician services meeting those criteria will be paid (1) on the basis of usual and customary charges subject to Medicare's prevailing fee limits if (2) the physician charges all patients for these services and if (3) the physician retains the fees. Where the physician does not retain all fees but assigns them to an entity which pays the physician a salary, Medicare will use the physician's salary, rather than billed charges, to determine the physician's fee. In the regulatory preamble, HCFA indicates some type of exception will be permitted for physicians' services provided in teaching hospitals. The form and extent of such an exception is not specified in these regulations.

While the proposed regulations apply to all specialties, special payment conditions are proposed for anesthesiology, pathology, radiology, and leased departments.

- Anesthesiology: If a physician personally performs a single anesthesia procedure, he/she would be paid a full fee. If a physician personally directs no more than two concurrent anesthesia procedures, he/she would be paid on a reasonable charge basis with a full fee allowed for each procedure if the physician employs the anesthetist. If a physician

supervises more than two concurrent anesthesia procedures, the physician's services would be defined as hospital services payable only on a reasonable cost basis through the hospital.

- Pathology: In general, clinical pathology services would be paid only on a reasonable cost basis through the hospital because these services are frequently and consistently performed by nonphysicians. An exception, allowing fee for service payment, would be made (1) for formal, written consultation on patients with abnormal test results and (2) for certain clinical laboratory services a physician personally performs for an individual patient.

- Radiology: Services for both inpatients and outpatients would be divided into those generally available in physicians' offices and those generally provided only in hospitals. Reasonable charges for services performed in a hospital, but generally available in physicians' offices, would be allowed if they did not exceed 40% of the prevailing fee for office-based services. Reasonable charges for services generally performed only in hospitals would be determined using the present prevailing fee limits.

- For services furnished in leased departments, Medicare would have the authority to "look through" the lease and separate the leased department into (1) physicians' services furnished to individual patients and payable on a reasonable charge basis and (2) all other activities payable only on a reasonable cost basis through the hospital.

When a physician service does not meet all three criteria used to identify services to individual patients, Medicare would allow the physician to be compensated only through the hospital's cost report. While the form of the hospital-physician compensation arrangement is not prescribed by the regulation, Medicare would limit the hospital's allowable costs for physicians' services to the lesser of actual costs incurred or a compensation ceiling set by specialty and location and published on page 43587.

Lastly, the regulations propose elimination of the combined charge form (HCFA 1554) presently used by some hospitals. When this form is used, separate charges for each physician service are not identified.

AAMC Initial Concerns

This proposed rule is very complicated and may have far reaching impacts on relationships between physicians and hospitals. HCFA has allowed only a 30 day comment period. AAMC members are urged to immediately write Secretary Richard S. Schweiker requesting extension of the comment period to 90 days.

While this proposed rule raises many issues that must be considered to assess its local impact, the following five seem to be of most general concern.

1. If a physician bills all patients and retains all income from services to individual patients, the proposed regulations would use billed charges to determine the physician's usual and customary fees. If, however, the physician assigns his fees to an entity and that entity compensates the physician for his

services to individual patients, the physician's usual and customary fees would be determined using the compensation received by the physician from the entity. While the proposed regulations indicate that some type of undefined exception will be proposed for physicians practicing in teaching hospitals, the AAMC has repeatedly taken the position that the way in which a properly earned fee is used should not alter the amount of the fee allowed. HCFA should be strongly urged to revise the regulations to permit all physicians in all hospitals to be paid on the basis of billed charges for services to individual patients unless the physician elects to have his fees determined using his compensation.

2. The proposed regulations do not clearly ensure that the appropriate portion of a physician's total compensation will be matched with the corresponding portion of his/her time allocation in applying the reasonable compensation equivalent or computing fees based on compensation. HCFA should be encouraged to revise the regulation to ensure (1) that compensation for services provided to the hospitals is compared only with the time actually spent performing those services and (2) that where compensation-based fees for individual patient services are elected, only the time spent and compensation received for individual patient services should be used to determine fees.

3. The proposed regulation generally eliminates Medicare payment on a fee-for-service basis for clinical pathology. The Association believes it is unnecessary to preclude all fee-for-service arrangements in order to address the government's concerns. In 1979, a report from the Senate Finance Committee, Senate Report 96-471, would have permitted compensation for pathology services based on an approved relative value scale "...which takes into consideration such physician's time and effort consistent with the inherent complexity of procedures and services." The AAMC continues to support a relative value scale approach as one compensation approach for pathology services.

4. In commenting upon the allowed compensation limits, AAMC members should recognize that the limits published on page 43587 are based upon a work year of 2080 hours (52 weeks of 40 hours per week). A salaried physician who works 60 hours per week would be permitted 1 1/2 times the published ceiling. This HCFA approach necessitates that hospitals use time, rather than effort, data to compute full-time equivalents and the resulting limitation.

5. Physician billings which are not permitted under the regulations would be treated as violations of the hospital's Medicare provider agreement. While the AAMC could support holding the hospital responsible for physician billings made by the hospital, the Association cannot support holding the hospital responsible for the billing violations of each member of its medical staff, even if the responsibility extends only to services provided in the hospital. Therefore, the AAMC believes HCFA should revise the regulations to hold physicians and their billing agents solely responsible for billings for physicians' services made in violations of any final regulations.

LIMITATION ON REIMBURSABLE COSTS AND RATE OF HOSPITAL COST INCREASES

Regulatory Status

1. Interim Final Rule with Comment Period
2. Effective Date: Cost reporting periods beginning on or after October 1, 1982
3. Comment Date: through November 29, 1982

Publication

Federal Register of September 30, 1982, pp. 43282-43293

SCHEDULE OF LIMITS ON HOSPITAL INPATIENT OPERATING COSTS

Regulatory Status

1. Interim Final Notice with Comment Period
2. Effective Date: cost reporting periods beginning on or after October 1, 1982
3. Comment Date: through November 29, 1982

Publication

Federal Register of September 30, 1982, pp. 43296-43338

Summary

These two regulations, taken together, establish the basic conceptual framework for two separate limits on Medicare allowable hospital payments: (1) the three-year "target" limit on allowable hospital cost increases, and (2) the Section 223 payment limits for hospitals. In establishing the general framework to limit allowable costs, the regulations are revised to reflect the change from per diem limits only on routine costs to per case limits on all inpatient operating costs. The regulations define inpatient operating costs subject to the percentage increase and 223 limits as inpatient costs per discharge excluding capital-related costs, malpractice insurance costs, and medical and nursing education costs in approved programs. Under both limits, adjustments to the limits are proposed for significant and abrupt changes in case mix and for decreases in inpatient services.

In specifying the three-year "target" limit on the percentage increase in allowable costs, the base period used for calculating the allowed increase is the cost reporting period beginning on or after October 1, 1981, while the first period subject to the limit is the cost reporting period beginning on or after October 1, 1982. In the second and third years, allowable limits are set on the basis of prior year limits, not prior year costs. HCFA estimates that the adjustment allowed for inflation and technology will be 7.9% for fiscal year 1983 and 8.6% for fiscal year 1984. The actual increase allowed in determining Medicare payments will be the inflation estimate available at time of settlement, plus 1%. Hospitals with cost increases less than the allowed percentage increase will be paid their allowable costs plus half of the difference between their

costs and the limit (to a maximum of 5% of their limit). Hospitals with cost increases more than the allowed percentage increase will be paid their limit plus only 25% of the costs above the limit. No hospital may be paid more, however, than its Section 223 limit.

The new Section 223 methodology continues several of the procedures presently used to set the routine per diem limit: (1) hospitals are grouped by bed size and rural/urban location, (2) costs are separated into labor and nonlabor components, (3) the labor component is adjusted for differences in area wage levels, and (4) a limit adjustment is provided based on the number of full-time-equivalent interns and residents per bed. Under the new limits, the limit threshold is raised from the current 108% to 120% in FY 1983. However, it is then reduced to 115% in FY 1984 and 110% in FY 1985. In a major change in the Section 223 methodology, a specific adjustment is provided to account for the relative costliness of a hospital's patient case mix. The regulation provides information on the case mix calculation and the market-basket used to trend forward historical data. A worksheet for computing the hospital's 223 limit is enclosed. The regulations exclude from the 223 limits hospitals with less than 50 beds, children's hospitals, long-term care hospitals, sole community providers, new providers, and risk-based HMO hospitals.

Under the two per case payment limits, the hospital will be entitled to the lesser of its percentage increase limit or its Section 223 limit. If the payment allowed under the lesser of the limits is below the hospital's per case operating costs in the cost reporting period ending on or after October 1, 1981, a "hold harmless" provision requires the intermediary to pay the base period operating costs per case.

Initial AAMC Concerns

1. The case mix methodology in the regulations uses calendar year 1980 discharges to classify patients and any of several fiscal years to compute the costs for each patient. Because cost-to-charge ratios and per diem room costs change annually, HCFA's methodology may miscalculate the costs of many patients. Therefore, HCFA should revise its methodology to ensure that the same period of time is used for both patient diagnostic and estimated cost data.

2. In developing the case mix index, HCFA used a 20% sample of Medicare patients and excluded from the calculation all patients whose estimated costs were beyond three standard deviations from the geometric mean for a specific diagnosis related group (DRG). Because teaching hospitals often care for a larger variety of patients and have a higher percentage of the atypically expensive patients, this data sampling and exclusion penalizes teaching hospitals. HCFA's case mix weights should be revised to include all discharges, even those with atypical costs.

3. While HCFA will allow a hospital to submit retrospective data to correct its published case mix index, this is permitted only for the first limit year. Until the publication of these regulations, hospitals had no necessary incentive to improve diagnostic and procedure data on the HCFA 1453 billing form. Calendar 1981 data which may be used for next year's limits also probably contains incomplete or inaccurate data. Therefore, the regulations should be revised to permit hospitals to submit corrected data for the case mix index until all of the data used to construct the index was submitted for patients admitted after October 1, 1982.

Worksheet for Computing Section 223 Limits
on Hospital Inpatient Operating Costs per Case

Step	Amount
1. Using Table I (urban hospital) or Table II (rural hospitals), identify labor-related component of limit for specific bed size group	_____
2. Using Area Wage Index from Table IIIA (urban hospitals) or Table IIIB (rural hospitals), identify wage index	_____
3. Multiply Step #1 by Step #2 to obtain adjusted labor component	_____
4. Using Table I (urban hospitals) or Table II (rural hospitals), identify nonlabor component of limit for specific bed size group	_____
5. Add Steps #3 and #4	_____
6. Using Appendix II, identify hospital's case mix index using provider number	_____
7. Multiply Step #5 by Step #6	_____
8. Determine Education Adjustment	
8a. Enter number of full-time-equivalent residents being trained at your hospital	_____
8b. Enter number of hospital beds	_____
8c. Divide Step #8a by #8b	_____
8d. Divide Step #8c by 0.1	_____
8e. Resident per bed adjustment	6.06
8f. Multiply Step #8d by #8e	_____
8g. Multiply Step #7 by Step #8f	_____
9. Add Step #7 and Step #8g This is the hospital's per case Section limit <u>if</u> cost reporting year begins on October 1, 1982	_____
10. <u>If</u> cost reporting year begins after October 1, 1982, enter appropriate reporting year adjustment from Table V	_____
11. Multiply Step #9 by Step #10 This is the hospital's per case Section limit	_____

4. HCFA will allow a hospital to substitute actual data on all of its Medicare discharges for the case mix index only when the hospital can show that the substitution is necessary due to a specific change in organization, range of services, or another particular and identifiable event. This is too restrictive. Hospital patient mix can change substantially between two years without clearly defined organizational changes. The regulations should be revised to permit a hospital to use actual data rather than the sample-based index at any time.

5. In the September 30th notice, HCFA has provided no information on the cost weights used for each diagnosis related group. As a result, hospitals cannot validate the case mix index they received. Hospitals also cannot assess the impact of different mixes on the index. HCFA should immediately publish the cost weights for each of the DRGs and a detailed description of the changes HCFA made in the DRG classification system.

6. HCFA has invited specific comments on suggestions for adjusting the percentage increase and Section 223 limits to account for cost differences incurred by hospitals providing services to a disproportionate number of low income or Medicare patients. Hospitals which can demonstrate such cost differences are urged to suggest appropriate adjustments to HCFA.

7. If Medicare implements the regulations proposed for physicians' services provided in an institutional setting, hospital costs for physicians' salaries and clinical laboratories will increase. HCFA should clearly state in the final regulations for both the percentage and Section 223 limits that increased hospital costs resulting from implementation of Medicare regulations not existing in the base year will be excluded from the computation in determining compliance, bonus payments, and penalties.

LIMITATION OF REASONABLE CHARGES FOR SERVICES IN HOSPITAL OUTPATIENT SETTINGS

Regulatory Status

1. Final Rule with Comment Period
2. Effective Date: Otober 1, 1982
3. Comment Date: Accept comments mailed by November 30, 1982

Publication

Federal Register of October 1, 1982, pp. 43610-43616

Summary

In general, Medicare allowable fees for services provided in physician offices, where the physician incurs overhead and practice expenses, have been the same as allowable Medicare fees for physician services provided in hospital outpatient settings, where the hospital can submit a claim for the overhead costs of clinics. Under this regulation, Medicare fees for physicians' services provided in a hospital outpatient setting where the hospital recovers outpatient overhead costs from the Medicare program, will be reduced to 60% of the fee allowed for similar services provided in a physician's private office. Services

excluded from the reduction to 60% of the prevailing fee are rural health clinic services, ambulatory surgical services, emergency room services provided to prevent death or serious health impairment, services paid on the basis of compensation-related fees, anesthesia services, and radiology services. Local Medicare carriers will determine the services covered by the fee reduction and apply the reduction to emergency, outpatient, and clinic settings.

AAMC Initial Concerns

1. If a hospital follows Medicare accounting requirements, outpatient clinic and emergency service overhead will be greater than the overhead of an office practice. To provide equity between hospital and office services, HCFA should revise the regulations to pay 100% of prevailing fees when physicians in hospital outpatient settings make overhead payments comparable to those incurred in private offices.

2. Office-based physicians seldom incur costs for residency training, but Medicare cost principles require hospitals to include residency costs in the overhead of outpatient clinics and emergency services. HCFA should revise the regulations to permit physicians in hospital settings to be paid 100% of prevailing fees even if a hospital claims overhead costs for educational programs.

3. No regulatory standard is provided for defining services "routinely provided" in office settings. Different carriers may establish substantially different criteria for defining "routinely provided."

4. In determining Medicare payments, the regulation proposes using 60% of the nonspecialist prevailing charge. Outpatient and emergency services in teaching hospitals are provided primarily by specialists, and HCFA should revise the regulations to use the specialist prevailing charge when a specialist provides the patient service.

5. The regulation invites public comment on the appropriateness of allowing full fee payment in emergency services only for services necessary to prevent death or serious health impairment. It is important that comments and suggestions on the reasonableness of this approach be made.

ASSISTANTS AT SURGERY

Regulatory Status

1. Interim Final Rule with Comments
2. Effective Date: October 1, 1982
3. Comment Date: Accept comments mailed by November 1, 1982

Publication

Federal Register of October 1, 1982, pp. 43650-43654

Summary

For the services of assistants at surgery, Medicare payment in all hospitals is limited to no more than 20% of the area prevailing fee for the surgical procedure. In addition, in teaching hospitals, Medicare will not pay for an assistant at surgery in a specialty having a training program except for exceptional medical services, complex procedures requiring a team of physicians, or patients requiring the services of a physician of another specialty. If the teaching hospital documents that no resident was available to assist in a particular case, an assistant at surgery fee may be allowed.

AAMC Initial Concerns

1. The regulation presumes that a resident is always available if the hospital has a training program related to the required surgical procedure. No consideration is given to affiliated hospitals with small training programs or those in which all surgeons do not involve residents in the care of their patients. HCFA should revise the regulation to permit payment for an assistant at surgery where the surgeon does not involve a resident in the care of his patient.

2. The regulation states "failure to adequately schedule a resident's time does not constitute unavailability" to serve as a surgical assistant. The statement implies no recognition for the non-O.R. components of surgical training and appears to require that a surgical resident be available for operating room time irrespective of other necessary educational responsibilities. AAMC members should communicate the importance of non-O.R. activities for surgeons in training.

3. Use by HCFA of a trauma case to exemplify exceptional medical service involving primary and assisting surgeons may more accurately illustrate a circumstance in which a team of physicians should each be entitled to a primary surgeon's fee. Clarification of this point should be requested.

ELIMINATION OF MEDICARE INDIRECT SUBSIDY FOR PRIVATE ROOMS

Regulatory Status

1. Interim Final Rule
2. Effective Date: October 1, 1982
3. Comment Date: Accept comments mailed by October 28, 1982

Publication

Federal Register of September 28, 1982, pp. 42676-42682

Summary

This regulatory change which is effective October 1, 1982 attempts to ensure that Medicare payments are not helping to fund private room accommodations used by Medicare patients unless that use is medically necessary. The regulation discusses a methodology which will be required to estimate the per diem cost by

which private accommodations exceed the costs of semi-private accommodations. Once this private room differential is calculated, the allowable cost of inpatient general routine services furnished to Medicare patients is determined by: (1) multiplying the per diem inpatient general routine service cost, excluding the private room cost differential, by the number of days of care furnished Medicare beneficiaries and (2) adding to this the product of the per diem private room cost differential times the number of days of care furnished Medicare beneficiaries in medically necessary private rooms. If a patient does not require a private room but elects it as a matter of personal preference, the hospital may continue to bill the patient for the difference between private and semi-private room charges.

AAMC Initial Concerns

1. Because the hospital's overall cost-to-charge ratio is applied to room charges to estimate the "cost difference" between private and semi-private rooms, the added costs of private rooms may be substantially overstated. The regulations should be modified to provide the hospital with an option of using generally accepted cost accounting procedures to estimate the additional costs of private rooms.

ELIMINATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL

Regulatory Status

1. Final Rule with Comment Period
2. Effective Date: October 1, 1982
3. Comment Date: through November 29, 1982

Publication

Federal Register of October 1, 1982, pp. 43618-43621

Summary

Eliminates the nursing salary differential in hospitals and skilled nursing facilities, effective October 1, 1982. For providers with fiscal years ending other than on September 30, 1982, the present differential will be allowed for the portion of a cost reporting period preceding October 1, 1982.

TREATMENT OF COST OF UNCOMPENSATED SERVICES FURNISHED IN FULFILLMENT OF A HILL-BURTON FREE CARE OBLICATION

Regulatory Status

1. Final Rule with Comment Period
2. Effective Date: Except for a court ruling applying to Presbyterian Hospital of Dallas, retroactive to the beginning of the

Medicare program
3. Comment Date: through November 30, 1982

Publication

Federal Register of October 1, 1982, pp. 43656-43658

Summary

Explicitly disallows from allowable Medicare costs any costs incurred in furnishing care under a Hill-Burton uncompensated service obligation. Disallowal is retroactive to the beginning of the Medicare program.

SCHEDULE OF LIMITS ON HOME HEALTH AGENCY COSTS PER VISIT

Regulatory Status

1. Final Notice with Comment Period
2. Effective Date: Cost reporting periods beginning on or after September 3, 1982
3. Comment Date: through November 29, 1982

Publication

Federal Register of September 29, 1982, pp. 42904-42913

Summary

This final notice, which applies to both the Medicare and Medicaid programs, sets an aggregate limit on home health visit costs as a function of visit volume and a limitation for each type of visit. The visit limit, which is set at the 75th percentile of labor costs and the 75th percentile of nonlabor costs for home health agencies grouped by rural/urban location, applies to both freestanding and hospital-based agencies. In addition, hospital-based agencies have a per visit "add on" estimated to account for higher costs attributable to Medicare cost allocation procedures.

SCHEDULE OF LIMITS ON SKILLED NURSING FACILITY INPATIENT ROUTINE SERVICE COSTS

Regulatory Status

1. Final Notice with Comment Period
2. Effective Date: Cost reporting periods beginning on or after October 1, 1982
3. Comment Date: through November 29, 1982

Publication

Federal Register of September 29, 1982, pp. 42894-42902

Summary

This final notice establishes limits on inpatient routine service costs for both freestanding and hospital based skilled-nursing facilities. The per diem limit, which excludes capital costs, is set at 112% of the mean labor-related costs and 112% of the nonlabor costs for skilled nursing facilities grouped by rural/urban location. Area wage indices are used to adjust each facility's limit and hospitals have a per diem "add on" estimated to account for higher costs attributable to Medicare cost allocation procedures.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #82-58 October 21, 1982

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals

FROM: John A. D. Cooper, M.D., President

SUBJECT: Taking Advantage of the Congressional Election Recess

Members of Congress will be in their states and districts through November for the election recess. This campaign period provides an excellent opportunity for AAMC constituents to meet with their Senators and Representatives to discuss pending legislation of concern to academic medical centers. Although the congressional schedule for the lame duck session beginning November 29 will be dominated by appropriation matters, it is likely that, as time permits, other legislative initiatives nearing resolution will be considered. Items of interest to the constituency that may be subject to action during the lame duck session include the following:

FY 1983 Appropriations

Members should be urged to press for Senate action on an FY 1983 Appropriations bill that:

- Meets or exceeds the House allocation of just over $4 billion for the NIH.
- Instructs the NIH to fully reimburse indirect costs.
- Repudiates any cap on the Health Education Assistance Loan (HEAL) program.

Background information is provided in Attachment I.

Animal Research Legislation

Members should be urged to reject all efforts to pass either House, H.R. 6928 or Senate, S. 2948. Bills in this area should be opposed on the grounds that they:

- Constitute unnecessary, costly and intrusive legislation, that ironically provides considerably more statutory protection for animals than is currently provided for human subjects in the course of research.

Efforts to persuade all of your legislators of the dangers of this type of legislation are vitally important, given the growing political power and prowess of both the animal welfare and the anti-vivisectionist movements. One can only view with alarm the fact that plans to form an animal welfare political action committee are well underway.

Background information is provided in Attachment II.

NIH Renewal Legislation

Senators should be urged not to support amendments to the Senate NIH bill S. 2311, which would provide statutory directives to the NIH Director concerning:

- The internal managerial operations of the NIH.
- The direction, priority and funding for specific areas of research.

Other damaging amendments that will probably be appended to the bill include:

- The creation of separate research institutes, such as arthritis, and separate authorizations for areas of research such as spinal cord regeneration.
- The creation of what is virtually a statutory entitlement or set-aside for the National Cancer Institute's Organ Site Program, including a bypass of the traditional NIH peer review system via a separate review system outside the control of the NIH (The Moynihan Amendment).

- A prohibition on the support of any research "on a living human fetus or infant, whether before or after induced abortion, unless such research is done for the purposes of insuring the survival of that fetus or infant".

These represent just a few of the numerous directives contained in the House passed NIH bill. Any provision in the House bill is fair game for addition to S. 2311 by amendment during floor debate in the Senate.

For the long haul, it would be useful to try to convince all members of the virtues of simple renewals and the ultimate return of the Cancer and Heart Institutes to the NIH's open ended Title III authority.

Background information is provided in Attachment III.

Proposed Medicare Fee Regulation

In discussions with Representatives and Senators you are strongly encouraged to raise the issue of the proposed regulations on the "Payment of Physicians Services Furnished in Institutional Providers of Service (e.g., hospitals)". Members should be urged to:

- Oppose that portion of the regulatory proposal which would mandate compensation-based fees for physicians paid on a salary basis.

- Support the principle that the disposition or use of a fee should not alter the amount of a Medicare fee.

Background information is provided in Attachment IV.

ATTACHMENT I

FY 1983 APPROPRIATIONS

The Continuing Resolution for FY 1983

Shortly before recessing in anticipation of the upcoming elections, the Congress enacted yet another stop gap funding measure, P.L. 97-276. The act extends appropriations for the vast bulk of the programs under the auspices of the Department of Health and Human Services (HHS)---including the Health Education Assistance Loan (HEAL) program---at FY 1982 levels until December 17, 1982. Language included in both chambers' version of the CR specified that all activities were to be continued under "current terms and conditions" effectively derailing the Administration's attempt to reduce reimbursement for indirect costs. Although the Senate specified that the NIH was to be treated as a special case, and thus temporarily funded it at a level $205 million above the President's FY 1983 request of $3.75 billion, the Office of Management and Budget (OMB) has apparently decided to disregard such instructions and is effectively withholding the anticipated increase.

The House Funding Bill

The House Appropriations Committee cleared an FY 1983 Labor/HHS/Education bill, H.R. 7205, on September 29---the Senate has yet to engage in similar action. The appended chart depicts the Committee's recommended funding levels.

The House Committee was firm in its dictum that the NIH and ADAMHA continue to fully reimburse indirect costs stating in its report that "the Committee...reached the conclusion that a flat, across the board reduction in one component of cost is not an intelligent or equitable way to deal with them...indirect costs are a legitimate component of the costs incurred in performing biomedical research and should be adequately reimbursed."

The Committee displayed similar resolve on the HEAL program repudiating the proposed $80 million cap "...since Public Law 97-35 established a limit of $225 million in the basic statute".

For further information contact Melinda Hatton (202/828-0525).

APPROPRIATIONS

(in millions)

	FY 1982	President's Request FY 1983	House Subcommittee Allocation FY 1983	Senate Subcommittee Allocation FY 1983	Conference Allocation FY 1983	1st Continuing Resolution FY 1983
NIH						
NCI	$ 943.0	955.4	981.4			--
NHLBI	559.6	577.1	620.9			--
NIDR	72.0	74.5	80.3			--
NIADDK	368.2	378.0	408.5			--
NINCDS	265.9	274.5	294.4			--
NIAID	235.9	246.0	276.4			--
NIGMS	335.5	345.6	376.0			--
NICHHD	226.3	233.6	251.6			--
NEI	81.9	84.5	96.1			--
NIEHS	127.4	131.5	138.8			--
NIA	154.3	157.4	162.7			--
RR	184.2	191.0	227.6			--
FIC	9.2	10.1	10.1			--
NLM	45.0	46.0	46.0			--
Director	23.6	24.3	24.7			--
Building, etc.	9.9	17.5	17.5			--
TOTAL	3,641.9	3,748.8	4,004.1			3,954.3
NIH Research Training	(155.8)	(151.7)	(170.3)			(--)
ADAMHA						
NIHM						
Research	141.1	150.0	152.3			141.1
Research Training	15.4	14.4	14.4			15.4
Clinical Training	42.2	--	18.0			42.2
NIDA						
Research	41.0	46.3	47.4			41.0
Research Training	.8	.9	.9			.8
Clinical Training	2.7	--	--			2.7
NIAAA						
Research	23.4	32.9	33.5			23.4
Research Training	1.1	1.1	1.1			1.1
Clinical Training	.9	--	--			.9
HEALTH SERVICES ADMINISTRATION						
National Health Service Corps Scholarship	36.4	11.0	11.0			36.4
NHSC Field Program	95.0	103.4	93.0			95.0
Health Professions Students Loans (HPSLs)	5.6	--	2.0			5.6

	FY 1982	President's Request FY 1983	House Subcommittee Allocation FY 1983	Senate Subcommittee Allocation FY 1983	Conference Allocation FY 1983	1st Continuing Resolution FY 1983
HEALTH SERVICES ADMINISTRATION (cont.)						
Exceptional Need Scholarships	4.7	--	6.5			4.7
Primary Care Block Grant (3 programs)[1]	448.8	416.7	446.2			448.8
Maternal & Child Health Block Grant (9 programs)[2]	373.7	350.0	373.0			373.7
Health Education Assistance Loans (HEAL) -- Credit Limit	200.0	80.0	225.0			200.0
HEALTH RESOURCES ADMINISTRATION						
Family Medicine Training	28.9	22.5	26.9			34.0
Family Medicine Department	7.7	7.0	7.7			7.7
General Internal Medicine and Pediatrics	16.3	11.4	11.4			16.3
Area Health Education Centers	18.2	13.9	17.9			18.2
Disadvantaged Assistance	16.9	17.2	17.2			16.9
Preventive Medicine Residencies	--	1.0	1.0			--
Curriculum Development	--	4.4	--			--
Health Planning	64.4	2.1	defer			64.4
ASSISTANT SECRETARY FOR HEALTH						
National Center for:						
Health Services Research	16.2	16.1	16.1			16.2
Health Statistics	38.2	40.3	40.3			38.2
Preventive Health Block Grant	81.6	82.6	82.6			81.6
ADAMHA Services Block Grant	432.0	432.0	424.0			432.0
OFFICE OF HUMAN DEVELOPMENT SERVICES						
National Institute for Handicapped Research	28.6	26.5	28.6			28.6
VETERANS ADMINISTRATION						
Medical Care	7,101.0	7,495.9	7,512.7	7,493.8	7,510.6	--

	FY 1982	President's Request FY 1983	House Subcommittee Allocation FY 1983	Senate Subcommittee Allocation FY 1983	Conference Allocation FY 1983	1st Continuing Resolution FY 1983
VETERANS ADMINISTRATION (cont.)						
Medical & Prosthetic Research	140.8	138.0	155.0	150.3	152.7	--
Construction						
Major Projects	372.3	419.4	427.1	409.4	407.4	--
Minor Projects	102.0	192.1	141.7	141.7	141.7	--

*Based on the Administration's reductions which involved a 4-6% cut plus a $7 million reduction for the NIH in administrative costs, and includes the transfer of funds from NCI and NIEHS and NIGMS to NCI.

[1]FY-1983 figues assume inclusion of three new programs, Black Lung, Migrant Health and Family Planning that totalled $165 million in FY-1982.

[2]FY-1983 figures assume inclusion of Women, Infant and Children Feeding Program that cost $900 million in FY-1982.

ATTACHMENT II

ANIMAL RESEARCH LEGISLATION

Summary of House Bill H.R. 6928

Legislation H.R. 6928, "The Humane Care and Development of of Substitutes for Animals in Research Act", sponsored by Representative Doug Walgren (D-PA), has been approved by the full House Science & Technology Committee. At the last moment, Mr. Walgren was dissuaded from appending his proposal to the NIH renewal bill, H.R. 6457, which recently passed the House, in exchange for a commitment from Chairman Henry A. Waxman (D-CA), of the House Subcommittee on Health and the Environment, that the Subcommittee would consider legislation in this area, either in the lame duck session or the new Congress.

The most troublesome provisions of the bill are those making Federal research support contingent upon fulfillment of specified accreditation and assurance requirements.

Accreditation. In terms of accreditation requirements the bill would mandate research entities to achieve compliance with the standards prescribed by the American Association for Accreditation of Laboratory Animal Care (AAALAC) over a ten year period. No funding is authorized to assist institutions in attaining compliance. It should be noted that while approximately 75 medical schools are accredited, 50 are not, nor are 80% of NIH grantee institutions. The Congressional Budget Office has estimated that the cost to research entities would be $500 million.

Assurances. Essentially, the bill would cast in statute many of the details and policies set forth in the NIH's "Policy on Humane Care and Use of Animals". However, the bill's reach extends beyond these guidelines. Institutions would be required to establish animal studies committees to be comprised of: one veterinarian; one member not affiliated with the institution and "who is primarily responsible for representing community concerns regarding the welfare of the animal subjects"; and no more than three members from the same administrative unit of the grantee institution. The Committee would be mandated to undertake scientific review functions not within its scope of expertise such as the review of research methods and practices in progress and the condition of the animals for the purpose of evaluating compliance with the originally approved protocol and with accepted standards for appropriate treatment and use and ensuring that animal pain and distress are minimized. These judgements have always been made through the national system of peer review.

Also, the Congressional Budget Office has estimated that the cost of reporting requirements of this bill---expenses research entities would have to bear---to be approximately $65 million a year.

In addition, the assurance requirements would involve two separate "whistle-blowing" procedures:

- Members of the animal studies committee will "be encouraged individually" to notify the Animal and Plant Health Inspection Service of the Department of Agriculture, the granting Federal agency and the accrediting agency of "any unacceptable conditions of animal care, treatment, or use, which have not been reported by the committee as a whole and which have persisted despite notification to the research entity".

- Research entities will be required to inform their employees of these provisions and to instruct them to report any violations to the animal care committee. The bill further provides that no employees will be discriminated against as a result of such reporting.

Development of Non-Animal Testing Methods. The bill includes authority for the now very familiar non-animal testing methods program, although authorization of appropriations have been deleted; instead it is now provided that funding for this program "will be made available by the Secretary by allocation of research resources within the Department of Health and Human Services." Those proposals approved but not funded through other HHS programs, would be considered for funding under the new program by a "Special Advisory Panel" which the bill would establish.

Summary of Senate Bill S. 2948

Legislation S. 2948 has also been introduced into the Senate by Senator Robert Dole (R-KA). It is possible that Mr. Dole could try and append this to the Senate NIH renewal bill, S. 2311, if it comes to the floor during the lame duck session.

Mr. Dole's bill is virtually identical to the Walgren proposal with the following exceptions:

- Language directing the non-affiliated member of the animal studies committee to protect any trade secrets of the research entity is included.

- The accreditation requirements of the bill will be held in abeyance depending upon the results of a one-year study by the HHS Secretary on the possible economic impact of mandatory accreditation on research laboratories. Following completion of this study, the Secretary will issue implementation regulations based on the results of the study.

For further information contact Mary McGrane (202/828-0525).

ATTACHMENT III

RENEWAL LEGISLATION CONCERNING THE NATIONAL INSTITUTES OF HEALTH

Two very different proposals have emerged as a result of the need to renew various expiring NIH authorities. While the authorization ceilings in the House-passed proposal are considerably more generous than in the Senate bill, the former is also weighed down with a new institute and numerous disease specific directives, studies and earmarks; the Senate proposal adopts a considerably more flexible and modest approach.

H.R. 6457, "The Health Research Extension Act of 1982".

The original bill sponsored by Mr. Waxman has undergone substantial expansion and modification in the period between its initial introduction and its passage by the House. The bill renews a variety of expiring NIH authorities at levels approximately 7% above those in the Senate bill.

In addition to the renewals of authority, the bill contains a host of other provisions including:

- The statutory establishment of the NIH as well as the authorities of its Director and specification of many of its functions and operations.
- Extensive revision of an addition to the statutory descriptions of each of the 11 National Institutes as currently embodied in Title IV of the Public Health Service Act. The report accompanying the bill stresses Congressional intent that the NIH no longer rely on its open-ended authority, thus setting the stage for time and dollar limits on each of the institutes.
- Creation of a new National Institute of Arthritis and Musculoskeletal Diseases with the renaming of the residue of the NIAMDKD, the National Institute of Diabetes and Digestive and Kidney Diseases.
- A mandate that the Director of NIH "establish a process for the prompt and appropriate response to information provided the Director respecting scientific fraud...and incidence of violations of the rights of human subjects of research..."
- Statutory provisions concerning peer review of intramural research and extramural contracts.

- A $3 million set-aside of NIH appropriations to carry out the functions of the National Center for Health Care Technology (NCHCT).

- A mandate for a study to examine the questions surrounding the commercialization of biomedical research.

- The transfer of the National Center for Health Statistics (NCHS) and the National Center for Health Services Research (NCHSR) to the NIH.

- The establishment of an NIH Assistant Director for Prevention and offices to administer and promote such research programs within each of the institutes, together with a requirement for a "prevention plan" for NIH supported research.

- The establishment of a separate line authorization for the cancer research and demonstration centers currently funded under NCI's aggregate appropriation.

- The establishment of an interagency committee on spinal cord regeneration.

- A separate authorization for basic and clinical research on spinal cord regeneration with spending ceilings of $16, $18 and $20 million for FY 1983-1985.

- The establishment of a program of Centers for Research and Demonstration of Health Promotion and Disease Prevention with authorization ceilings of $10, $20, and $25 million for FY 1983-1985.

- A study of the role of diet therapy in the treatment of end stage renal disease to be submitted to the Congress by January 1, 1986; authorization of appropriations of $1 million for each of the next three years.

- A study by the new arthritis institute to be submitted to the Congress by the end of 1982 on the expansion of research on arthritis and musculoskeletal diseases by and through the Institute.

- A study on the safety and effectiveness of the pertussis vaccine.

- A study of the adequacy and availability of personnel to meet the health care needs of the elderly.

- The establishment of an interagency committee on learning disabilities.

- An ambiguously worded prohibition on fetal research of specified characteristics.

- A directive for the NIH to continue the cystic fibrosis center.

S. 2311, "The Biomedical Research, Training and Medical Library Assistance Amendments of 1982".

This bill was introduced by Senator Orrin Hatch, Chairman of the Senate Committee on Labor and Human Resources and will most likely go to the floor during the lame duck session.

While the authorization levels are far from adequate, they are, surprisingly, 3% above the administration's FY 1983 budget proposals. In other respects, the statutory provisions are far less intrusive than those embodied in the House proposals.

In addition to the renewal of various expiring authorities, S. 2311 also includes provisions for:

- The establishment of a National Kidney Diseases Advisory Board.

- The repeal of the payback requirement associated with awards under the National Research Service Award Program.

- Reauthorization of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research for the next two years with annual authorization ceilings of $1.1 million.

- Addressing a number of controversial subjects through reporting requirements. It mandates that the Secretary report procedures to the Congress on:

  - "any activities undertaken...to improve the grant, contracting, accountability, and peer review procedures of the NIH (including the NCI)"; and

  - "all activities of the NIH...relating to preventive medicine and health promotion including the number and type of personnel involved in such activities".

- Requiring the director of each institute to notify the Advisory Boards of the status of any investigation concerning any recipient of a grant or contract unless the office conducting the investigation advises that such disclosure will jeopardize the investigation.

- Mandating that the NIH director establish procedures for the appeal of determinations made by the peer review system.

- Establishing a seven-member "President's Council for the Health Sciences" to develop a "National Health Sciences Plan" to set forth long-term research priorities. This represents a diluted version of the Council proposed in the NIH bill championed by Senator Edward Kennedy in the 96th Congress. The Council has a two year life-span with funding ceilings of $750,000 for each year. The Report specifies the Committee's intent that the Council: document the extent of duplicative Federal research; identify any underdeveloped areas of research which "show great promise"; and identify and facilitate coordination of research throughout the Federal government.

For further information contact Mary McGrane (202/828-0525).

ATTACHMENT IV

PROPOSED MEDICARE FEE REGULATION

In Memorandum #82-56 on regulatory changes in the Medicare program, you were furnished a copy of proposed regulations on the "Payment of Physicians Services Furnished in Institutional Providers of Service (e.g., hospitals)." The proposed regulations raise a serious question about the way Medicare fees will be determined for physicians who are paid on a salary basis for professional medical and surgical services provided to individual patients. Under the regulations, Medicare officials view a reasonable fee for a physician's service to be the charges billed and retained by the physician, Section 405.481(d)(2), or the compensation paid to the physician by the hospital or any other entity. Charges billed in excess of personal compensation received are assumed by the regulations to constitute an unnecessary profit that should not be paid (column 1, page 43584 of the Federal Register). This point of view, that net revenue from fees is inappropriate, could undermine the financial benefits of present practice plans, medical foundations, and hospital group practice arrangements.

Though the proposed regulations refer to the possibility of some exception to compensation-based fees for salaried physicians in teaching hospitals, Section 405,551(b), it may be difficult to retain any exception that clearly pays physicians in teaching hospitals more generously than others. The AAMC has repeatedly taken the positions that (1) all physicians in all hospitals should be paid on the basis of billed charges for services to individual patients unless the physician elects fees determined using his/her compensation and (2) the way in which a properly earned fee is used should not alter the amount of the fee.

For further information contact James Bentley (202/828-0493).

GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN PROJECT HEARINGS

The General Professional Education of the Physician Project will enter its second year in January 1983. A status report on the project was distributed to AAMC Annual Meeting Registrants. Over 7,500 copies of the Working Group Charges booklet have been distributed. Eighty-seven medical schools and 20 professorial societies are organizing discussions on the Essential Knowledge, Fundamental Skills, and Personal Qualities, Values, and Attitudes that comprise the general professional education of the physician.

In 1983 the advisory panel will hold hearings in the four AAMC regions. The schedule for these hearings is:

University of California, San Francisco - January 27
University of Texas, Houston - February 24
Northwestern University - March 24
New York Academy of Medicine - May 5

The purpose of the hearings is to provide an opportunity for medical schools, academic societies, and individuals to exchange views with the panel on the changes needed in medical education and college preparation. CAS member societies have been urged to inform their members of the hearing schedule.

FINANCIAL ASSISTANCE FOR MEDICAL STUDENTS

The overall funding for federal student financial aid programs available to medical students remains cloudy because a final FY 1983 Federal Budget has not been approved. However, the status of some of the principal federal sources of financial support as of October 15, 1982 is described below:

- The Guaranteed Student Loan (GSL) Program has stabilized somewhat. The President's recommendation to bar graduate and professional students from the program received no congressional support. While the Department of Education reports GSL borrowing to be slightly less during FY 1982, it is likely that there will be further, if not virtually annual, attempts to reduce spending for this entitlement program which in academic year 1981-82 supplied 49 percent of all financial aid and 72 percent of all loans to medical students.

- The Health Education Assistance Loan (HEAL) Program (currently at 16.5 percent interest plus a .25 percent insurance premium) continues to grow. The $48 million borrowed through HEAL in FY 1981 could climb to $100 million in FY 1982 when data on all HEAL loans for that period are finally compiled. The Department of Health and Human Services presently has commitments for $170 million to be borrowed from HEAL and the medical schools have projected a need for $118 million in HEAL funds during FY 1983. The total FY 1983 HEAL requirement for all eligible schools could be near the $225 million authorized ceiling. The Administration's attempt to cap the program at $80 million appears to have been overridden by the House Appropriations Committee although some doubt still remains about the ultimate availability of HEAL funds for the coming year. Should this "last resort" loan be denied to significant numbers of students, the result could be catastrophic. In any event, increased HEAL borrowing will mean more rapid escalation of the indebtedness of medical students which for the 83 percent of students with debt reached $21,051 in 1982.

- The Health Professions Student Loans (HPSL) Program is under attack from proposed regulations published August 31, 1982 by the Department of Health and Human Services aimed at improving HPSL collections. The Association of American Medical Colleges estimates that approximately two thirds of the medical schools could be excluded from the HPSL program if the proposed regulations are not substantially modified. While the recent appropriations for this program have been relatively small, the HPSL funds collected and reloaned at most medical schools are substantial and both are threatened by the regulations. This program and the Exceptional Financial Need (EFN) Scholarship Program are the only two federal student aid programs targeted to "exceptionally needy" students.

APPROPRIATIONS

(in Millions)

	FY 1981	FY 1982	1983 PRESIDENT's REQUEST	1983 HOUSE APPROPRIATIONS COMMITTEE ALLOCATION
National Direct Student Loans*	186.0	178.6	0	178.6
College Work Study*	550.0	528.0	397.5	528.0
Health Professions Student Loans	16.5	5.6	0	2.0
Exceptional Financial Need Scholarships	10.0	4.0	0	6.5
National Health Service Corps Scholarships**	63.4	36.4	11.0	11.0
Health Education Assistance Loans+	520.0	200.0	80.0	225.0
Guaranteed Student Loans++	2,535.5	3,073.8	2,484.6	2,484.6

* Data on amounts only to health professions schools is not available.
**No new positions will be available in the National Health Service Corps Scholarship Program for FY 1983.
+ Authorized Spending Levels.
++Actual or anticipated spending levels for this entitlement program

aamc association of american medical colleges

October 13, 1982

Director
Bureau of Health Personnel Development
and Service
5600 Fishers Lane
Parklawn Building, Room 6A05
Rockville, Maryland 20857

Dear Director:

The Association of American Medical Colleges represents all 127 U.S. medical schools and their students, more than 70 faculty societies and over 400 teaching hospitals. This letter is a response on behalf of these constituents to the notice of proposed rulemaking, 42CFR Part 57, addressing the Health Professions Student Loan (HPSL) Program published in the August 31, 1982 Federal Register.

The Association as a cosigner endorses the October 13, 1982 response to these proposed rules from a group of Associations representing the health professions, the Federation of Schools of the Health Professions. In so far as medicine is concerned the following matters need additional elucidation:

- HPSL collections at medical schools increased substantially from June 30, 1981 to June 30, 1982. During this period data from over one half of the medical schools indicate an average improvement in their collection rate of 44.6 percent. However, doubt remains about the ability of schools to meet the performance standards prescribed in the proposed rules over the short time period they require. The report of the House Appropriations Committee urges the Secretary to assure that "schools which are doing a satisfactory job in managing their loan program" are not penalized. Nonetheless, the same data cited above reveals that as of June 30, 1982 the proposed performance standards would exclude approximately 66 percent of medical schools from the HPSL program. Furthermore, there is no evidence to suggest that substantial improvement in collections will continue to be made once delinquent accounts are reduced to the more hard core non-payers. Schools are not professionals in loan collection. The presumption that the majority of them can achieve below a 5 percent standard is unfounded particularly when the delinquency rate for such secured commercial loans as 1 to 4 unit mortgages exceeds that standard for the second quarter of this year.

- The HPSL program is intended to assist low-income students. This is a particularly high risk group and the attempted intervention of standards not achievable by commercial lenders providing loans to selected borrowers and secured by collateral, undermines the purpose of the program. To the degree that these proposed regulations dismantle the HPSL program, they reduce the ability of the schools to financially assist these students many of whom come from minority groups underrepresented in medicine. If

adopted, the rules threaten the progress that has been made in the enrollment of low income and underrepresented minority students in medical schools.

- The formula to compute delinquencies includes the total principal balance outstanding on delinquent loans, not simply the delinquent principal. The term delinquency connotes a temporary shortage which will ultimately be made good. The term default indicates a failure to repay. Since the vast majority of HPSL accounts are, in fact, only delinquent, it is inappropriate to include total principal outstanding in the formula--only the delinquent principal should be applied. To demonstrate that the majority of delinquencies in the HPSL program are temporary, UCLA School of Medicine tracked all delinquent accounts identified as of June 30, 1981 for one year. By June 30, 1982,70 percent of these accounts were current and all but 10 percent had made progress toward repayment.

- A monthly repayment schedule is mandated by these proposed rules. While a priori such a schedule would appear to have a salutary effect upon collections, there is no evidence to support that HPSL accounts collected on a 30 day schedule have a lower delinquency rate than those on quarterly or annual repayment. Furthermore, monthly billing imposes an administrative and financial burden on the schools which is unjustified and in some instances may actually impede the collection effort. New York University School of Medicine estimates that monthly billing for all accounts will more than double the administrative costs without assurance of improvement in their HPSL collections. Finally, such a schedule could not be applied to borrowers currently in repayment without their acquiescence to a modification of the terms of their repayment agreements.

- Some of the delinquent borrowers have not received the M.D. degree. The proposed rules take no cognizance of the fact that schools have less leverage to collect from these non-graduates who may not have the financial means to repay. The failure to repay HPSL funds by the relatively higher risk students who do not complete the M.D. degree serves to reinforce the inherent concern of the schools about the admission of such students. If some relief for the non-degree recipients could be added to the proposed regulations, it would lessen some of the pressure for both the students and the schools caused by apprehension about their completion of the degree program.

- The Department has certified that these proposed regulations would not have a significant impact on a substantial number of small entities, and therefore do not require analysis under the Regulatory Flexibility Act of 1980. This certification is entirely unsupported given the potential for these rules to effectively terminate a loan program with over $100 million dollars in revolving funds in health professions schools, the loss of which would not only have a significant institutional impact, but could deprive many individuals of the financial ability to pursue a career in medicine. Similarly, the amount of

funding placed in jeopardy by these rules which, as indicated above, exceeds $100 million dollars warrants compliance with Executive Order 12291.

The Association fully subscribes to the principal that all medical student borrowers should repay all education loans fully and on schedule. However, as the foregoing indicates, the Association believes the essence of the proposed rules to be destructive to the HPSL program and to maintenance of a heterogeneous mix of medical school students both in terms of financial and ethnic backgrounds. We would welcome the opportunity for discussions about their revision.

Sincerely,

John A. D. Cooper

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

FEDERATION OF ASSOCIATIONS
OF SCHOOLS OF THE HEALTH PROFESSIONS
One Dupont Circle, Suite 810 Washington, D.C. 20036

OFFICE OF CHAIRMAN

October 14, 1982

Director, Bureau of Health
Personnel Development and Services
5600 Fishers Lane
Parklawn Building, Rm. 6A-05
Rockville, Maryland 20857

Dear Director:

The Federation of Associations of Schools of the Health Professions is comprised of associations which represent health professions education in the United States. We present here our joint response, which reflects the grave concern we share with regard to the rulemaking proposed in the August 31, 1982 Federal Register for the Health Professions Student Loan Program (HPSL). Each of the Federation member associations directly affected by the proposed rule (Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, American Association of Dental Schools, Association of American Veterinary Medical Colleges, Association of Schools and Colleges of Optometry, American Association of Colleges of Pharmacy, and American Association of Colleges of Podiatric Medicine) will file a supplemental comment specifically addressing the probable impact of the proposed rule on its individual professional schools.

The Notice of proposed rulemaking (NPRM) summary states that the purpose of the proposed rule is to "strengthen the regulations regarding recordkeeping and collection procedures and establish performance standards against which a health professions school's delinquency rate would be measured." While we support and encourage efforts to improve debt collection we believe many elements of the proposed rule are unrelated to the stated purpose, and would contravene congressional intent in establishing and reauthorizing the program. The proposed rule will, in fact, force the HPSL program into liquidation at most schools.

Although the data for the year ending June 30, 1982 are unavailable from the Bureau at present, we believe the most recent statistics will show that our schools have significantly lowered their delinquency rates since June 30, 1981. Despite their efforts, we estimate that a minimum of 70 percent of the health professions schools currently participating in the HPSL program would be forced into inactive status were the proposed rule made final today.

As you know, we have expressed serious reservations about this proposal since the plan was outlined by the Bureau of Health Personnel Development and Service in Policy Memorandum Number Two dated March, 1982. Numerous alternatives were offered by associations and institutions concerned with developing a workable approach to debt collection for the HPSL program. We see no evidence, however, that our comments were given adequate review in the process of formulating the proposed rule. Overwhelming problems remain with the proposed performance standard mandating less than 5 percent in borrower or dollar delinquency calculated on a 30 day basis according to a new formula.

Specifically, this comment:

1) questions the existence of a statutory basis for the proposed rule;

2) details the arbitrary and capricious nature of the proposed rule; and

3) provides a section-by-section analysis of the impact of the proposed rule on participating institutions.

1. The proposed rule is inconsistent with congressional intent.

There is no statutory basis for this proposed rule. The authorizing legislation does not now contain, nor has it ever contained, language directing the Secretary to promulgate regulations concerning the methods by which schools collect HPSL loans.

Although the legal basis relied on in proposing this rule has never been specified, the Bureau apparently intends to rely on either §740(b)(6) or §744. To do so, however, is to misread the statute.

Section 740 authorizes the Secretary to enter into agreements with schools to establish loan funds and specifies the elements of these agreements, including "provisions as are necessary to protect the financial interests of the United States" [§740 (b)(6)]. Although a broad reading of these words may be offered as supportive of the proposed rule, to do so reads too much into a clause permitting standard protective language in a government contract. Moreover, such stretching would overlook the plain meaning of §740 and the purpose of the Act, taken as a whole. Section 740, in fact, creates the HPSL program. The proposed regulation would establish unrealistic performance standards which would effectively terminate the program; such a result contravenes the intent of Congress. If such a slender reed as Subsection 740(b)(6) could be used to support a proposed rule, virtually any governmental program could be repealed, without congressional action, through a rulemaking procedure.

Section 744 addresses the Secretary's authority to modify agreements entered into under this program. This section allows the Secretary to release institutions or students from contractual obligations; it does

not imply a similar delegation of responsibility for determining which institutions will be allowed continued participation in the program.

Finally, the rule would result in a forced liquidation of the HPSL fund for most institutions. (Schools which fail to meet the performance standards would not be allowed to roll over amounts collected to make new loans, but would have to return the collections to the Treasury.) This, too, violates congressional intent. The statute specifies how assets are to be distributed from the loan fund at the end of the program; §743 describes this process. No liquidation before September 30, 1987 is implied.

Because no specific statutory basis can be found to support the proposed rule, the Bureau may claim a general rulemaking authority is implied in the Act. However, it is clear from a review of this statute that Congress did not intend such a broad delegation of authority to the executive branch. The statute specifies those elements of the program for which the Secretary should assume authority. Examples include §741(d) [definition of permanent and total disability]; §741(f)(3) [definition of student loan cancellation eligibility]; §741(j) [authority to formulate regulations concerning assessment of a late fee]; and §742(b)(1) [authority to set dates by which a school may file application for Federal Capital Contribution].

In fact, schools are given broad authority for program operation. For example, §741(b) refers to "such [loan] terms and conditions as the school may determine". The proposed regulation would diminish the ability of schools to operate their programs. There is no basis in the law for such a fundamental shift of responsibility away from participating institutions and into the Bureau.

Finally, it appears the Department intends to rely on prior regulations (e.g., §57.218 of the HPSL regulations issued May 18, 1979) as authority for elements of the proposed rule. This cannot be done. The proposed rule (or any rule) must find its authority in the statute it purports to implement. One rule will not support another rule, independent of the underlying statute.

Thus, no explicit or implicit statutory provision supports the promulgation of this rule.

An examination of the legislative history of the program further supports our position. Debt-collection questions would appear to have been a very minor consideration in the minds of the members of Congress who have reauthorized and amended the Health Manpower Law numerous times since 1963. The principal goal of the HPSL program has been consistently stated as providing a source of funds to help needy students secure an education. The emphasis was placed on encouraging the use of the loan program, as reflected in these comments from the House committee report on the 1971 legislation:

> As new schools come into being and existing schools are expanded to increase enrollment to relieve manpower shortages, funds must be available to assist needy students.
>
> In recent years there has been increasing concern over rising costs of professional education. A substantial proportion of health professions students go into debt before graduation. The health professions student loan program has made a major contribution in assisting students to undertake and complete professional education.
>
> ...Further, to encourage students of exceptional financial need to undertake indebtedness to secure a professional education, and to alleviate their concern that a loan might be an impossible burden if they should for some reason, be forced to leave school before completion of their professional studies, the bill would authorize repayment, in whole or in part, of any loan incurred for professional education if the student is in exceptionally needy circumstances, if from a low-income background, and cannot be expected to resume his studies within two years....
>
> The bill would replace the loan cancellation provisions of present law with new authority designed to provide greater incentives to physicians, dentists, and other health professionals to practice in areas where they are most needed-....(H.Rpt. 92-258, Committee on Interstate and Foreign Commerce, 92d Cong., 1st Sess., pp. 36-37)

Clearly, Congress intended to make loans accessible to students for their health-related education, so it would be possible for them to go to school. There was no mention of acceptable default rates or penalties for unacceptable rates; on the contrary, the committee reports have emphasized the loan forgiveness aspects of the program.

There is only limited evidence that the congressional leaders gave any thought to questions of debt collection. In the 1968 amendments a provision was added to permit the <u>school</u> to assess nominal penalties on a borrower who failed to make timely payment of an installment. A committee print for the Senate Labor and Public Welfare Committee explained the provision as follows:

> <u>Section 121(a)(4)(A)</u>.--The bill would authorize a school to charge a borrower for failure to pay all or any part of an installment when it is due or, if the borrower is entitled to postpone his repayments, or to cancel his repayment, for his failure to file timely evidence of such entitlement ($1 first month; $2 each month thereafter).
>
> The proposed amendment would permit participating schools to place greater emphasis on terms and conditions of repayment. (Committee Print, Senate Labor and Public Welfare Committee, accompanying S. 3095, 90th Cong., 2d Sess., at p. 122.)

It is readily apparent from this text that the intent of the committee was to give greater authority to the schools, not to mandate draconian collection practices.

It should be noted, too, that this language, which has been a part of the HPSL statutory authority since 1968, authorizes the schools to assess penalties on borrowers. In contrast, there is not now, nor has there ever been, a provision in the HPSL authorization which empowers the agency to assess any penalties on schools.

Other than this authority giving the schools added ability to operate the program efficiently, there has been no consideration of debt-collection problems in the various committee reports on reauthorization of the health manpower legislation. In considering the 1968 amendments, Congress received a recommendation from the Comptroller General (printed in H.Rpt. 90-1634, pp. 55-57) to add provisions to the statute which would mandate uniform recordkeeping and audit standards for all the health manpower programs. This recommendation was ignored by Congress, without comment in the committee report.

In the face of the great need to encourage students from lower-income backgrounds to pursue health careers, little concern was given to loan collections. Likewise, this has been the orientation of the Bureau until very recently. Now, without any congressional mandate, and without any statutory authorization, the Bureau proposes to demand rigid performance standards of the schools. Further, the Bureau proposes to apply these standards retroactively, basing eligibility on the schools' performance during a period prior even to the proposal of the standards.

2. <u>The proposed performance standards are arbitrary and capricious.</u>

Even if, for the sake of argument, the rule were deemed consistent with congressional intent, close examination of its elements will show them to be unrelated to the purpose of improving debt collection in the HPSL program. The proposed rule includes some elements which are vague and unworkable; other requirements are drawn too tightly--without considering the varying characteristics of the diverse participating institutions and students.

- 5 Percent Maximum Delinquency Standard

As the Secretary concedes in the proposed rule itself (p. 38367), schools have limited expertise in loan collection compared to the commercial banking community. Justification of the debt collection performance standards on the basis of commercial bank experience is, therefore, inappropriate. In addition, the Bureau has randomly selected a misleading frame of reference. A 5 percent delinquency standard is, in fact, not consistent with experience in the commercial banking community. The mortgage delinquency rate on 1- to 4-unit residential loans reached 5.56 percent in the second quarter of 1982 (National Delinquency Survey, Mortgage Bankers Association of America, 9/13/82).

If banks suffer a delinquency rate of over 5 percent on loans secured by real property, the hope that less expert university lenders can experience a lower rate on student loans is unfounded.

The rigid 5 percent standard ignores changing economic conditions that impact on delinquency rates despite the best collection efforts of lenders. Moreover, the proposed 5 percent standard ignores regional differences. Some schools provide health professionals primarily for a particular state or region. Economic difficulties in that state or region will cause delinquency rates to vary. Thus, for example, the mortgage delinquency rate in Illinois was 8.51 percent in the second quarter of 1982, while the rate for the entire east north central region (Illinois, Indiana, Michigan, Ohio, Wisconsin) was 7.00 percent (ibid.). Given these realities, the imposition of a uniform 5 percent delinquency rate for student loans is particularly unjustified.

The 5 percent rate is also defended by reference to somewhat lower delinquency rates for loans such as auto loans and credit cards. Payments on these loans are often much smaller than on a student loan; indeed, minimum credit card payments may be only a small percentage of the balance due. The possibility of immediate repossession of an automobile or loss of a credit card provides a payment incentive absent with student loans. In any event, even using the Secretary's inappropriate comparison with various types of small loans, the fact remains that the rigid, uniform 5 percent rate does not reflect today's commercial reality in many regions. As of June 30, 1982, for example, the delinquency rate on home appliance loans exceeded 5 percent in New York and 8 percent in New Jersey (Delinquency Rates in Bank Installment Loans, Bulletin No. 420, American Bankers Association, Second Quarter, 1982). Even for credit cards, the delinquency rate exceeded 4 percent in New York (ibid.). Under these circumstances, the proposed 5 percent rate for student loans is unrealistic.

Also, as the comments below regarding HPSL delinquency rate formula point out, commercial delinquency rates are not directly comparable to the HPSL delinquency rates reported by schools. Banking institutions compute delinquency rates on no more than an annual basis. At the close of each fiscal year, defaulted loans must be written off as bad debts and such losses are then reflected in annual operating statements. Schools, on the other hand, have for the most part continued to carry uncollectable HPSL loans on their books from year to year. Therefore, current HPSL delinquency rates actually reflect cumulative uncollectables.

The NPRM cites a 1978 study that indicates "professionals" generally have a lower delinquency rate than the general population. As discussed previously, the HPSL program was designed to assist students from low-income families in attending professional schools. It is clearly inappropriate to compare a new graduate from a needy family with the average practicing professional when considering ability to repay a loan. Furthermore, some portion of delinquent HPSL borrowers are not "professionals" at all, but are former students who did not complete their education.

Finally, not only are universities not commercially-skilled lenders, but student borrowers are not comparable with consumers of commercial credit. The best tool employed by commercial lenders in avoiding loan delinquency is careful pre-loan assessment of credit risk. Commercial loan applicants must demonstrate credit worthiness. The commercial delinquency rates cited occur despite the banking community's ability to select "good" credit risks. Schools do not, nor should they according to the statutory foundation of the program, assess the credit worthiness of HPSL applicants. Quite to the contrary, HPSL awards are made on the basis of need. In this sense, HPSL recipients are by definition "high risk" borrowers.

• Thirty-day Definition of Delinquency

Although their responsibility to exercise "due diligence" in loan collection must be consistently met, schools will be hard pressed to operate as efficiently as lending institutions. With a 30-day standard, loans would be classified as delinquent before a school had reasonable opportunity to pursue their collection. While constant monitoring of loan accounts might be ideal, it would be a significant burden on institutions whose primary business is not loan management, particularly in view of the financial constraints facing all schools.

• Calculation of Delinquency Formula

The HPSL delinquency rate calculations as now proposed, as well as formulae employed previously, combine loan delinquency and default. The resultant rates are not representative of schools' current success in loan collection. Operating in good faith and in accordance with existing regulations, schools have carried uncollectable loans on their books year after year. Inclusion of such loans in rate computations actually measures cumulative delinquency. To calculate annual delinquency rates, uncollectable HPSL loans and those under bankruptcy proceedings should be excluded and separately reported as in default. (Please also see comments on due diligence requirements and bad debt write-off procedures, p. 10 and 11.)

• Vague or Unworkable Provisions

Several elements of the proposed regulations are vague and fail to define proposed procedures clearly. Such ambiguity suggests that insufficient time was devoted to the rulemaking process. For example, proposed §57.216 (a) would "require the return of all money collected until the Secretary determines that the school is in compliance". However, the notice does not specify where the money is to be returned nor what will be done with it once it is relinquished by the schools.

Section 57.216(a) also establishes a compliance date of March 31, 1983 without specifying whether the 5 percent standard required at that time would be calculated on a quarterly or annualized basis. The basis of this calculation is critical. All information reported prior to 6/30/82 was computed under one standard formula. The information to be derived

from the proposed new formula is substantially different. Since the proposed formula is incompatible with that used previously, an annualized rate (calculated from information obtained under two different formulae) would be impossible to compute.

Other unworkable provisions are discussed in the section-by-section analysis, p. 9 through 12.

• Lack of Response to Concerns Expressed by Participating Schools

The HPSL performance standards proposed in the August 31 Federal Register NPRM were first circulated to participating schools as part of the Bureau of Health Personnel Development and Service Policy Memorandum Number Two in March, 1982. Subsequently, representatives of the Bureau met with health professional school associations on several occasions to discuss the proposed standards. Bureau personnel also attended individual annual meetings of most associations. Numerous concerns, suggestions and possible alternatives were offered during these meetings, and in affected schools' and their national associations' written responses to the BHPDS Policy Memorandum Number Two. The proposed rule does not reflect the considerable input so obtained, nor address the concerns expressed.

Moreover, following U.S. Senate Committee on Governmental Affairs hearings on the subject of federal debt collection and publication of Policy Memorandum Number Two, national associations cooperated in fostering their members' efforts to strengthen HPSL loan management. Now sensitized to the need, health professional school administrations voluntarily intensified HPSL loan collection efforts, instituting a wide variety of innovative approaches and reforms. Schools were required to provide detailed information to the Bureau concerning their academic year 1982-83 debt collection characteristics by August 13, 1982. Although this report provided the first data regarding institutional efforts to improve collections, it was not analyzed in fashioning the proposed rule. Such arbitrary rulemaking lends support to those who believe this to be a thinly veiled attempt to eliminate the HPSL program.

• Inadequate Analysis of Impact of the Regulation

The Secretary's decision not to do analyses pursuant to the Regulatory Flexibility Act of 1980 or Executive Order 12291, is unjustified. We believe that most health professions schools must be considered "small entities" and that the proposed rule does have a "significant economic impact" on them. The paperwork and administrative burdens incidental to the rule are considerable--securing financial aid transcripts for every loan applicant; conversion to a monthly billing cycle for all accounts; mandating due diligence steps including use of collection agents and litigation; collection intervention on all past-due accounts to avoid 30-day delinquency status; quarterly rather than annual reporting and extensive record retention requirements. Most important, the cost-benefit of all of these requirements should certainly be evaluated when developing regulations. There is no other method of measuring the potential of the proposed rule to achieve its stated purpose.

3. Section by Section Analysis of Proposed Amendments to 42 CFR Part 57

§ 57.205 Collection Costs

Regulatory authority permitting reimbursement for costs of litigation; costs associated with membership in credit bureaus; and certain other collection costs that exceed usual expenses incurred in the collection of health professions student loans is desirable. We concur with this revision because the language is permissive.

§ 57.206. Financial Aid Transcripts

Many health professions schools have elected to require loan applicants to furnish a financial aid transcript. We agree that health professions schools should obtain information about HPSL applicants' financial aid history and status. These data are essential in counseling students on incurring additional indebtedness. However, the HPSL financial aid transcript as described in the 8/31/81 Notice of Proposed Rulemaking (requiring certification by signature of authorized official from each institution previously attended by the applicant of the amounts and sources of loans and grants previously received; indication of repayment status; lack of default; and, if applicable, indication that no financial aid was received) is unduly burdensome. The reasons given by the Secretary for this requirement are unsubstantiated. It is unclear how this information can "assist schools in determining the level of funding needed by students" or "provide the school with information regarding the credit worthiness of the students."

We favor regulatory language which encourages voluntary collection of this prior financial aid data only for the purpose of counseling students.

§ 57.208 HPSL Promissory Note

On a prospective basis, the requirement that HPSL promissory notes contain a clause allowing acceleration of delinquent loans at the school's option is desirable.

§ 57.210 (a)(3) Monthly Repayment Schedule

We find no evidence that mandatory monthly repayment schedules, as proposed, will improve HPSL debt collection. On the contrary, a number of health professions schools with excellent collection histories do not employ monthly repayment cycles. No analysis of the relative collection success of schools which presently bill on a monthly basis is provided in the proposed rule. Because this requirement is likely to result in a significant expense for schools and the program, its cost-benefit should be evaluated. For many borrower accounts, payments may be so small as not to indicate or justify monthly billings. Conversion to a monthly billing cycle may also violate existing loan agreements with students. Therefore, schools should retain the flexibility to design whatever repayment cycle is workable and productive for the school and the graduate.

§ 57.210(a)(4) Granting of Forbearance

The ability of schools to grant forbearance whenever extraordinary circumstances such as unemployment, poor health, or other personal problems temporarily affect the borrower's ability to make scheduled repayments is essential.

We not only agree that this change is called for, but we urge that accounts for which extraordinary circumstances are documented and forbearance is granted not be considered delinquent for purposes of computing the school's overall delinquency rate. Likewise, the process for granting forbearance should encourage partial repayment whenever possible during the fixed period of time for which forbearance is granted. Such partial payments should not jeopardize the borrower's forbearance status, nor should the school's delinquency rate be adversely affected.

§ 57.210(b)(1) Due Diligence

We totally agree that schools must be vigorous in collection efforts. However, "due diligence" which requires that a uniform set of procedures be applied to every delinquent loan will often be a wasted effort. The difficulty in defining due diligence for all cases is readily apparent in the ambiguity of the language used in the proposed rules describing what a school "must at least" do to demonstrate due diligence:

"(i) Use collection agents;"

It is unclear when and how the collection agent is to be used. Unquestionably, there are many cases in which a collection agent would be helpful in pursuing overdue loans. However, to make their use an absolute requirement is unwise because in numerous situations the use of an agent would be fruitless. To ensure cost-effectiveness, decisions about collection services are best left to the discretion of the school.

"(ii) Institute legal proceedings against borrowers after all other attempts at collection have failed, provided that such litigation is appropriate;"

This proposed revision is also unclear. The regulatory language itself is inconsistent--how can a mandatory action be performed when it "is appropriate"? Often the delinquent loan amount will not justify the cost of litigation.

"(iii) Become a member of a credit bureau and notify the credit bureau of all delinquent accounts;"

It is not unreasonable to require membership in a credit bureau, but notifying the bureau of all delinquent accounts seems harsh and unnecessary. Only accounts which are seriously delinquent should be reported to a bureau, and then only when borrower has been warned of the fact and when the loan agreement permits it. Retroactive application of this practice could result in violation of existing contracts with debtors. Also, in some states such reporting could conflict with state laws governing consumer protection and guaranteeing rights of privacy.

In summary, the elements of "due diligence" do not lend themselves to universal application and, therefore, should not be made mandatory. The full range of possible "due diligence" steps should be given to schools as examples.

Section 57.210 would require schools to reimburse the fund for amounts uncollected unless proof of due diligence was furnished and accepted by DHHS. The ability to write off loans under any circumstances is a very recent program development. Guidelines issued by the Department May 27, 1969, stated that a loan under the FCC option may not be written off as uncollectable until the end of the program. The possibility of writing off uncollectable loans was not mentioned again until October 1980 in the Student Financial Aid Guidelines (§111.55), and then the procedure was left sufficiently unclear to discourage its use by schools. As stated in the NPRM, neither "due diligence" (p.38366) nor performance standards (p.38365) have previously existed for the HPSL program. Thus a school which has been following program directives in good faith could now be penalized for prior behavior.

Requiring schools to reimburse their funds for uncollectable amounts on the books before the development of due diligence requirements and performance standards is inherently unfair. We strongly oppose retroactive imposition of due diligence standards in order for schools to write off defaulted loans.

§ 57.213(a) Loan Cancellation Reimbursement

The proposed procedure is equitable.

§ 57.215(a) Quarterly Reports

It would be excessive and wasteful to require quarterly reports. If a school's delinquency rate is acceptable, the quarterly report is clearly unnecessary. If a school has an unacceptable rate as determined in a quarterly report, punitive action could not be taken until the following academic year. To do otherwise would be totally unworkable because loan commitments are generally made on an annual basis. The loan program would be impossible to administer should penalties immediately result on a quarterly basis. A single annual report should be the only basis for determining collection performance.

§ 57.215(b) Record Retention

Retention of records for five years is inconsistent with paperwork reduction guidelines proposed by the Office of Management and Budget (Federal Register of September 8, 1982).

The retention of complete repayment records for loans fully retired as agreed is unnecessary. Such documentation should be required only for accounts which were uncollectable or loans otherwise not retired as originally agreed.

§ 57.216(a) Performance Standard

Comments on this section are included above, p. 5 through 7.

In summary, health professions schools recognize the necessity of augmenting fiscal responsibility in the operation of federally-funded programs, and support the Bureau in its effort to assure the continued existence of rollover funds by enhancing the effectiveness of collection efforts. The NPRM requirements, contrary to legislative intent, are so unrealistic in their demands upon the administrative apparatus of the health professions educational institutions as effectively to bar most of them from continued access to HPSL funds. We fail to comprehend the logic underlying the blind drive toward meeting an arbitrary and inappropriate standard of fiscal compliance which places in jeopardy the participation of most schools--and the students they serve--in the program, and may ultimately endanger the very existence of the HPSL program itself.

The proposed regulations clearly fail to provide participating institutions a realistic time period within which to improve their debt-collection practices, or to establish reasonable expectations for those practices rooted in an appreciation of the objectives and functional characteristics of academic institutions. The very nature of the health professions schools as training centers differentiates them from the economic expectations of private enterprise (specifically, of the commercial lender market) in structure, operation, and intent. Seeking to impose wholesale and unmodified the debt collection criteria common to commercial lending practice while failing to adjust for actual staffing patterns and the state of the art with respect to loan collections within academic institutions is tantamount to insuring the demise of the HPSL program at many schools, particularly those newer, smaller, and minority-oriented programs whose students are at greatest financial risk. At a time when the availability of traditional sources of financial aid for deserving health professions students is shrinking and educational costs escalating, any action which places further limitations on students' access to assistance can only be construed as both shortsighted and irresponsible.

We agree that problems exist with respect to debt collection procedures under HPSL, and we are eager to work with the Department in developing viable solutions to them. We continue to be willing to discuss reasonable alternatives which can be useful in achieving our mutual goal of fostering an efficient debt-management system for the HPSL program.

Thank you for the opportunity to comment.

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DECLINING APPLICANT POOL

The number of applicants to medical school has been on a downward trend since 1976. This trend is expected to continue and probably accelerate during the rest of this decade. Table 1 shows that there were 6,669 (16%) fewer applicants in 1982 than in 1975. Between 1981 and 1982 there was a three percent drop and a five to seven percent drop is forecast for 1983. During this period the number of matriculants has increased by 1,637 (11%) and the applicant/matriculant ratio has decreased from 2.84 to 2.15.

This decrease in competition has not been uniform across the states. Table 2 and Figure 1 show that in 1974 (when the national percent of applicants that were matriculated was 34%) only three states had 50 percent of their resident applicants admitted to a medical school. In 1982 14 states had 50 percent or more admitted. Kansas, at 60 percent, had the largest proportion admitted and Arizona and Hawaii had the smallest at 38 percent. The largest increase in percentage admitted was Rhode Island (25) and there were three states (Alabama, Georgia, and North Dakota) that had a decrease in the proportion of their resident applicants admitted to medical school between 1974 and 1982. This variability in competition for positions by state of residence suggests that medical schools with rigid state residency requirements may now and in the future have a lesser pool of talented applicants from which to select their matriculants.

Female applicants are steadily increasing in number (Table 1). In 1970 they constituted 11 percent of the total. In 1982 they were 33 percent of the pool. Male applicants have been steadily declining in number. Between 1981 and 1982 they decreased by 1,072 while the number of females remained constant. Women now make up 31 percent of the entering class.

Disadvantaged minority applicants have stayed relatively constant at nine percent of the applicants and eight percent of the matriculants through 1981.

Factors that are expected to accelerate the rate of decrease in applicants are (1) a decline in the number of college graduates, (2) the increased financial burden and scarcity of loan funds for medical students, and (3) the wide public discussion of a future physician surplus. Whether a downward trend in the number of positions in medical schools will parallel the applicant trend is conjectural, however, the number of matriculants in 1982 is 97 fewer than in 1981. This is the first year since 1952 that an actual decrease in first year enrollment has occurred.

Table 1

APPLICANTS AND NEW ENTRANTS

	1970	1975	1980	1981	(Approximate) 1982
Applicants					
Male	22,253 (89%)	32,728 (77%)	25,436 (70%)	25,054 (68%)	23,982 (67%)
Female	2,734 (11%)	9,575 (23%)	10,664 (30%)	11,673 (32%)	11,652 (33%)
TOTAL	24,987 (100%)	42,303 (100%)	36,100 (100%)	36,727 (100%)	35,634 (100%)
New Entrants					
Male	9,941 (89%)	11,398 (76%)	11,832 (71%)	11,532 (69%)	11,351 (69%)
Female	1,228 (11%)	3,512 (24%)	4,758 (29%)	5,112 (31%)	5,196 (31%)
TOTAL	11,169 (100%)	14,910 (100%)	16,590 (100%)	16,644 (100%)	16,547 (100%)
Applicants / New Entrants	2.24	2.84	2.17	2.20	2.15

DISADVANTAGED MINORITY APPLICANTS AND NEW ENTRANTS

	1975		1980		1981	
	Applicants	Entrants	Applicants	Entrants	Applicants	Entrants
Black American	2,288 (5%)*	945 (6%)	2,594 (7%)	1,057 (6%)	2,644 (7%)	1,037 (6%)
Native American	132 (.3%)	57 (.4%)	147 (.4%)	62 (.4%)	160 (.4%)	68 (.4%)
Mexican American	427 (1%)	220 (1%)	449 (1%)	191 (1%)	515 (1%)	281 (2%)
Mainland Puerto Rican	202 (.4%)	86 (.6%)	191 (.5%)	102 (.6%)	222 (.6%)	113 (.7%)
TOTAL	3,049 (7%)	1,308 (8%)	3,381 (9%)	1,412 (8%)	3,541 (9%)	1,499 (9%)

*percent of total

Table 2

MATRICULANTS AS PERCENTAGE OF APPLICANTS

STATE	1974	1980
Alaska	30%	41%
Alabama	45	44
Arkansas	34	43
Arizona	23	38
California	27	42
Colorado	34	41
Connecticut	33	45
Delaware	31	52
Florida	29	43
Georgia	41	39
Hawaii	33	38
Iowa	42	44
Idaho	33	51
Illinois	38	49
Indiana	40	51
Kansas	44	60
Kentucky	38	40
Louisiana	38	47
Massachusetts	28	46
Maryland	35	46
Maine	33	40
Michigan	32	42
Minnesota	38	47
Missouri	31	54
Mississippi	40	49
Montana	30	49
North Carolina	34	44
North Dakota	52	50
Nebraska	38	48
New Hampshire	32	39
New Jersey	31	49
New Mexico	28	40
Nevada	42	43
New York	37	51
Ohio	37	52
Oklahoma	33	43
Oregon	36	39
Pennsylvania	35	49
Rhode Island	34	59
South Carolina	35	54
South Dakota	50	59
Tennessee	23	49
Texas	38	52
Utah	27	44
Virginia	43	44
Vermont	35	49
Washington	33	42
Wisconsin	36	52
West Virginia	37	49
Wyoming	54	58

Percent of Applicants from each State Admitted to a Medical School

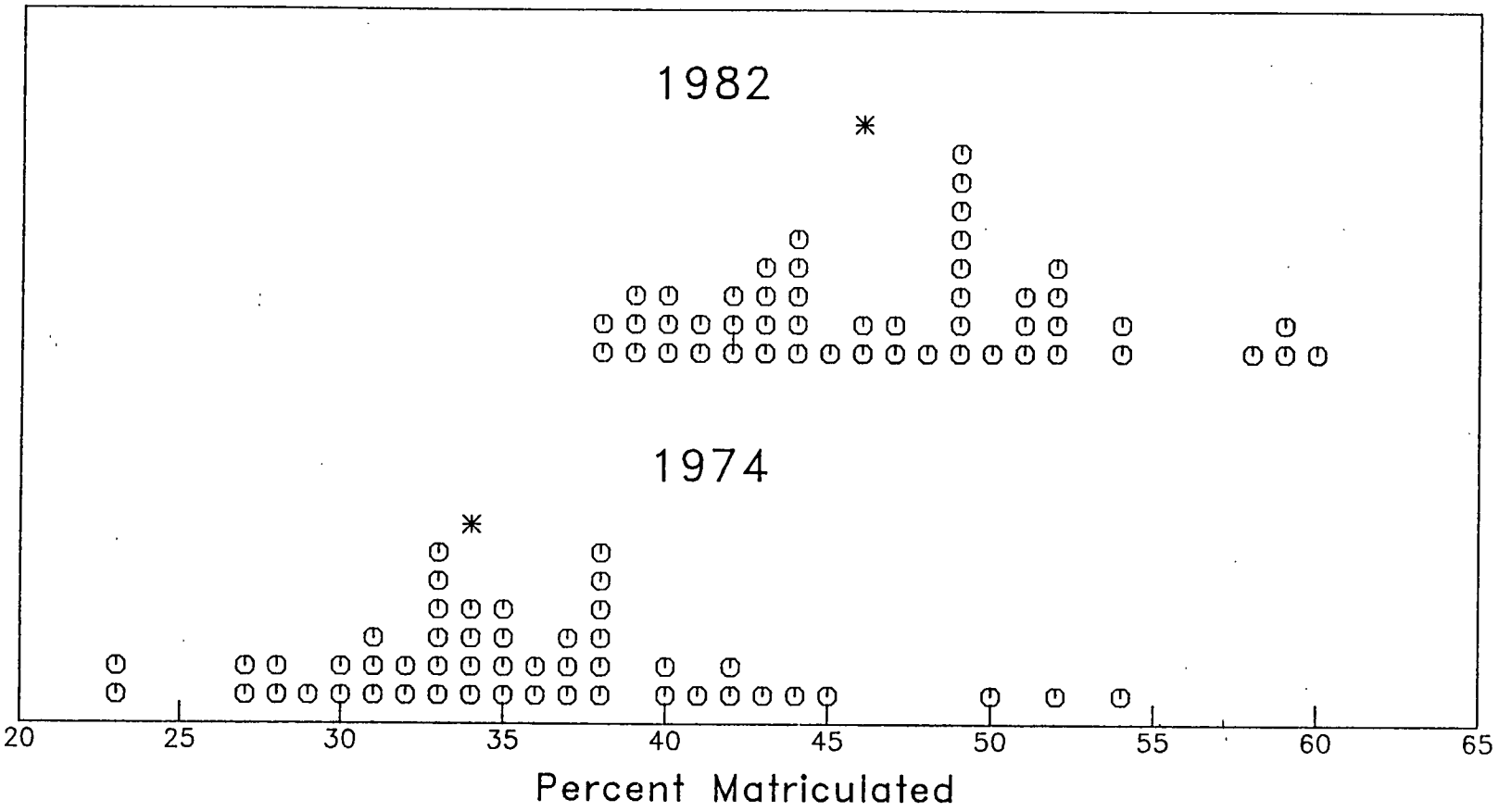
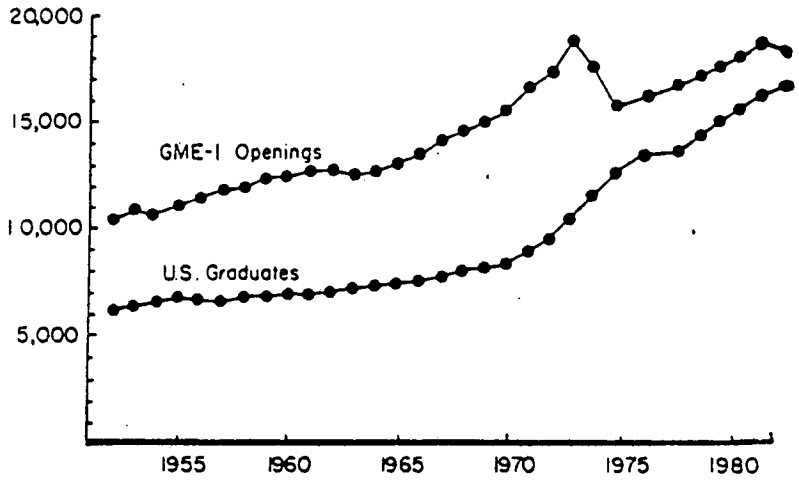


Figure 1

DECLINING NUMBERS OF GME POSITIONS

The 1982 National Resident Matching Program data indicate a narrowing of the ratio between the number of graduate medical education positions available and the number of graduates from U.S. medical schools (Figure 1).

Figure 1



For the first time in five years the total number of positions offered in the match was less than the previous year (Table 1). The specialties with decreased positions offered were family practice, pediatrics, general surgery, neurosurgery, and all of the support specialties. Internal medicine increased by two percent or 131 positions.

The number of graduates from U.S. schools is steadily increasing (Table 2). The ratio of positions to graduates in 1982 is 1.12. In 1978 the ratio was 1.2. The ratio is even narrower considering the fact that 23 percent of the programs in the Match that offered 2,200 (12 percent) of the total positions did not attract a single U.S. graduate applicant. Subtracting these positions results in a ratio of .99.

In 1982 92.1 percent of the U.S. graduates matched. This compares to 92.8 percent matching in 1981. Competition for positions among graduates of foreign schools increased significantly. Only 75 percent of the Fifth Pathway candidates matched as compared to 82 percent in 1981. U.S. foreign medical graduates matched at the 57 percent level as compared to 67 percent in 1981 and for aliens the percentage fell to 31 percent from 45 percent in 1981.

Jack Graettinger reports that for the first time, several institutions withdrew unfilled positions after the match.

Table 1

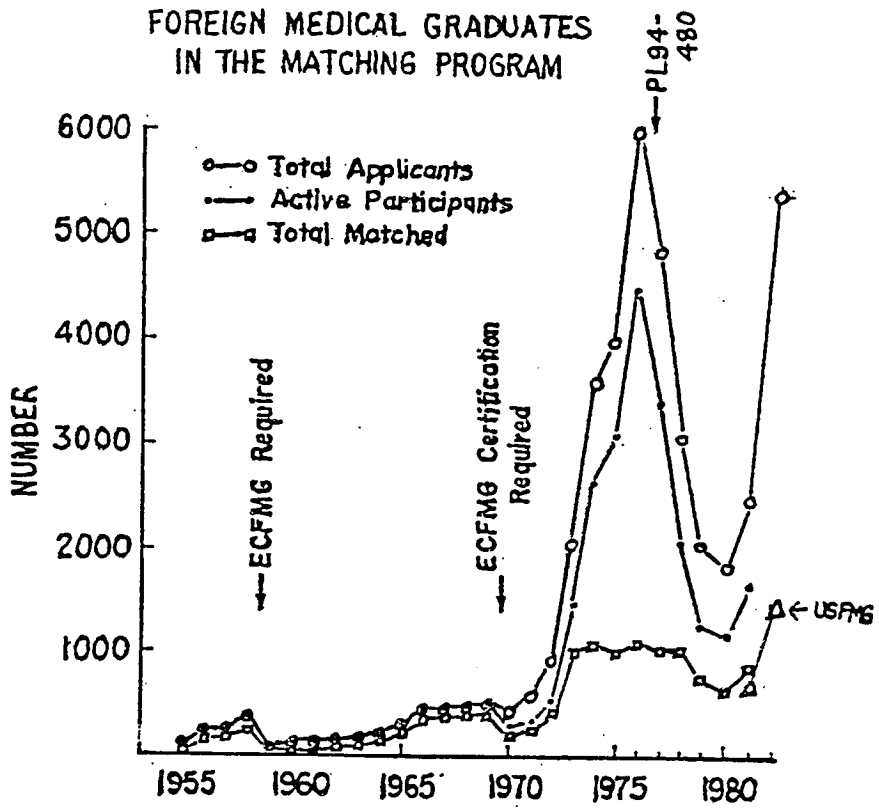
Positions Offered in Match
1978-1982

Type of Program	1978	1979	1980	1981	1982
Family Practice	2,111	2,251	2,340	2,370	2,362
General Practice	35	19	0	0	0
Internal Medicine	5,571	5,829	6,043	6,129	6,260
Pediatrics	1,776	1,833	1,808	1,833	1,810
Obstetrics	897	966	981	1,008	1,035
subtotal	10,390	10,898	11,172	11,340	11,467
Medical Specialties	1,074	1,074	1,050	1,032	1,031
Dermatology	(8)	(8)	(11)	(8)	(9)
Neurology	(86)	(73)	(74)	(74)	(72)
Ophthalmology	(41)	(27)	(32)	(27)	(28)
Psychiatry	(939)	(966)	(933)	(923)	(922)
General Surgery	2,310	2,393	2,369	2,407	2,340
Surgical Specialties	409	402	434	431	548
Neurosurgery	(37)	(39)	(41)	(45)	(40)
Orthopedics	(242)	(240)	(257)	(250)	(305)
Otolaryngology	(49)	(44)	(46)	(52)	(96)
Urology	(81)	(79)	(90)	(84)	(107)
Support Specialties	1,593	1,623	1,649	1,672	1,564
Anesthesiology	(448)	(466)	(518)	(526)	(507)
Pathology	(582)	(612)	(573)	(574)	(557)
Physical Medicine	(88)	(89)	(116)	(105)	(92)
Dx Radiology	(397)	(373)	(369)	(383)	(336)
Rx Radiology	(78)	(83)	(73)	(84)	(72)
Flexible	1,443	1,434	1,381	1,449	1,343
Total	17,219	17,824	18,055	18,331	18,293

Table 2

	1978	1979	1980	1981	1982
U.S. Graduates	14,393	14,966	15,135	15,623	16,300
Positions / Graduates	1.20	1.19	1.19	1.17	1.12

Table 3



APPLICANTS

	1981	1982	Change
US Graduates	15,496	16,000	+ 3%
5th Pathway	456	523	+ 15%
USFMG	785	1,400	+ 78%
Other	687	700	+ 2%
Sub-total US-Canadian Citizens	17,424	18,623	+ 7%
Alien FMG	1,731	4,000	+167%
Total	19,155	22,623	+ 18%
US-Canad Grads	16,183	16,700	+ 3%
Foreign Grads	2,972	5,923	+ 99%
Total	19,155	22,623	+ 18%

POSITIONS

1981=18,900
1982=19,480

POSITIONS PER APPLICANT

	1981	1982
US Canad Grad	1.17	1.17
US Citizen	1.08	1.05
All Applicants	0.97	0.86

Note: All 1982 data are approximate

$1 \bar{x} 81$

Table 4

HOSPITALS AND PROGRAMS THAT FILLED LESS THAN ONE-THIRD OF POSITIONS WITH U.S. GRADUATES IN THE NRMP IN 1982

State	Hospitals	Programs	Positions	U.S.G.	Others
Alabama	3	4	17	4	0
California	5	9	52	13	16
Connecticut	8	12	98	15	42
Delaware	1	1	4	0	0
Dist. Columbia	4	20	76	16	15
Florida	3	3	13	1	4
Georgia	2	3	21	3	0
Illinois	21	67	300	56	134
Indiana	1	1	4	0	0
Iowa	1	3	7	2	1
Kentucky	1	1	6	2	1
Louisiana	3	3	15	1	8
Maryland	6	20	66	6	21
Massachusetts	3	10	46	12	15
Michigan	10	24	123	29	28
Missouri	5	9	51	7	16
Nevada	1	5	26	9	0
New Jersey	20	49	217	32	105
New York	39	113	586	70	295
North Dakota	1	1	8	2	0
Ohio	10	45	201	35	31
Oregon	1	1	1	0	0
Pennsylvania	14	44	211	29	61
Puerto Rico	1	3	18	4	0
Rhode Island	2	4	19	5	2
Tennessee	4	5	23	3	1
Texas	2	2	8	0	6
West Virginia	1	4	13	2	3
Wisconsin	2	2	12	2	0
PAGE TOTAL	175	468	2,242	360 (16%)	805 (36%)
Total in Match	700	3,516	18,300	13,053	1,931
Page Total Percent of Match Total	25	13	12	3	42

Table 5

Number of Accredited Residency Programs by Specialty

Specialty	No. of Accredited Programs Oct. 79	June 80	Increase/ Decrease	Sep. 81	Increase/ Decrease
Allergy and Immunology	46	55	+ 9	73	+18
Anesthesiology	163	163		161	- 2
Colon and Rectal Surgery	27	27		26	- 1
Dermatology	97	97		99	+ 2
Dermatopathology	14	18	+ 4	20	+ 2
Family Practice	366	385	+19	385	
Internal Medicine	443	445	+ 2	443	- 2
Neurological Surgery	94	97	+ 3	93	- 4
Neurology	120	121	+ 1	123	+ 2
Nuclear Medicine	89	93	+ 4	93	
Obstetrics/Gynecology	306	306		304	- 2
Ophtalmology	163	160	- 3	155	- 5
Orthopedic Surgery	188	181	- 7	180	- 1
Otolaryngology	117	115	- 2	112	- 3
Pathology	358	359	+ 1	314	-45
Blood Banking	18	23	+ 5	29	+ 6
Forensic Pathology	36	36		35	- 1
Neuropathology	54	57	+ 3	54	- 3
Pediatrics	253	253		245	- 8
Pediatric Allergy	25	19	- 6	0	-19
Pediatric Cardiology	51	51		48	- 3
Physical Medicine and Rehab.	65	64	- 1	65	+ 1
Plastic Surgery	109	106	- 3	105	- 1
Preventive Medicine, General	32	33	+ 1	33	
Aerospace Medicine	3	3		3	
Occupational Medicine	26	26		27	+ 1
Public Health	18	19	+ 1	14	- 5
Psychiatry	232	232		223	- 9
Child Psychiatry	130	130		125	- 5
Radiology, Diagnostic	220	223	+ 3	221	- 2
Radiology, Diagnostic (Nuclear)	30	39	+ 9	43	+ 4
Radiology, Therapeutic	105	105		102	- 3
Surgery	352	352		331	-21
Pediatric Surgery	17	18	+ 1	18	
Thoracic Surgery	101	101		98	- 3
Urology	162	161	- 1	153	- 8
TOTAL	4,630	4,673		4,553	

BIOMEDICAL Ph.D. TRAINING PROGRAMS

Impact of a Changing Environment on the Medical Schools

HISTORICAL BACKGROUND

The United States has been a world leader in biomedical research for several decades and has developed the most sophisticated research apparatus in the world. This has been primarily a function of the large amount of research funding invested by the federal government which began in the late 1940's and peaked in the late 1970's (figure 1). Concomitantly, there was a rapid increase in the number of academic doctorate degrees awarded (fig.2). Beginning in the early 1960's, federal support for medical education grew, allowing a dramatic expansion in both the number of new and size of existing medical schools. Medical student enrollment more than doubled between 1960 and 1980. Medical school faculty size increased more than four-fold in the same time period (fig. 3).

Most observers agree that these halcyon days of exuberant growth in federal support for research and medical education are over. Federal biomedical research expenditures began to decline as a percentage of national health expenditures as early as 1965. Although R&D funding continues to increase in absolute terms, by FY 1979 the increases began to fall behind inflation. Within the past four years, biomedical research funding has suffered an absolute decline when measured in constant dollars. Even more problematic is that this decline in research funding must be spread over a much larger number of investigators that completed training and entered the research "labor force" over the past decade. As figure 4 indicates, research dollars per faculty member have been steadily declining since 1963. More than one third of the Ph.D's in the biomedical sciences, and nearly all of the combined M.D./Ph.D.'s receive their training within the medical schools proper, and many more within the universities that contain the colleges of medicine. 27 percent of the average medical school's budget is derived from research funding. Obviously, changes in research funding would have profound repercussions for medical schools.

The National Academy of Sciences/National Research Council addressed many of these issues in a year-long study entitled, "Personnel Needs and Training for Biomedical and Behavioral Research: 1981 Report". Copies of their data and projections are attached. Unfortunately, experience since the publication of the report has resembled their most conservative projections.

PROJECTED DEMAND FOR FACULTY

There are several determinants of the demand for faculty logically revolving around the tri-partite functions of teaching, research, and service. Determinants include enrollment of undergraduate and graduate candidates for academic and professional degrees; the magnitude of research support from government, and medical students; funding from NIH, industry, and foundations; and general demand for medical services. Although biomedical Ph.D.'s do not provide direct patient care, they often collaborate with clinicians who do. Fully half of all new Ph.D.'s hired in medical schools have joined clinical departments.

R & D Funding: From 1973 to the time of the NAS/NRC report (1979), NIH funded research increased at an annual rate of 6.7% in real dollars. Total life sciences R & D expenditures at colleges and universities increased at a more moderate 3% per year. The report projected a subsequent one percent per year increase in constant dollars, based on the expectations that trends would continue at a somewhat more modest pace. They have not. The president's budget for FY 1983 proposed a 3% reduction in constant dollars from the FY 1982 level, which followed upon an aggregate 10% reduction since FY 1979. Few see any dramatic growth in the immediate future.

Student Enrollment: Biomedical faculty size is at least in part related to student enrollment at the undergraduate, graduate, and medical school level. The National Academy of Sciences report notes that total undergraduate enrollment (including biomedical science enrollment) is declining because of demographic trends. Similarly, graduate student enrollment is likely to decline because of a decreased applicant pool, declining availability of fellowship support and the rather bleak outlook in job opportunities for Ph.D.'s. The increase in medical student enrollment has decelerated sharply in the last couple of years. The GMENAC Report's prediction of an impending physician surplus provided a rationale for eliminating federal incentives for expansion. Class size at most medical schools has leveled off and a few schools are considering or have taken actual measures to reduce class size. In summary, teaching opportunities in the biomedical sciences show no signs of expansion and are more likely to contract over the next decade.

Clinical Practice: In the last decade medical schools have come to rely increasingly on funds generated by clinical practice. This dependence has grown from less than three percent to over twenty percent of the average medical school budget. Availability of this source of revenue has facilitated the expansion of the clinical faculty but may also have diverted physician members from research. However, patient care revenues for academic medical centers will probably not continue to grow as rapidly as in the past. First, the inevitable cutbacks in medicare and medicaid will probably have a differentially severe impact on academic medical centers because they care for a disproportionate number of poor and elderly patients. Secondly, academic medical centers, whose costs tend to be increased because of the research and teaching activities associated with patient care, will find it increasingly difficult to maintain service revenues as the political climate evolves towards price competition.

EFFECTS OF ZERO GROWTH ON BIOMEDICAL RESEARCH FACULTY

Because the biomedical research community has become accustomed to growth, there will be some painful readjustments will be necessary if growth slows or stops. One major effect would be the "graying" of the faculty. The rapid growth in faculty over the last15 years has created a "bulge" in the age profile; i.e., a disproportionate fraction of young and middle aged. With any reduction in new appointments resulting from the economic circumstances, the mean age of the remaining faculty would gradually increase. It has been estimated that a continued growth of 6% per year is necessary to prevent this "graying" of the faculty. The implications of this are manifold. Among them is a top-heavy faculty in a period of austerity and retrenchment. Another major casualty of would probably be research productivity. Most research is carried out by the graduate students and the post doctoral fellows under faculty

supervision. Without these categories of personnel the scope and volume of faculty research would of necessity be curtailed. Even more fundamental concern would be the loss of a generation of young investigators who produce a great number of significant original contributions. A third major issue is the quality of training for the next generation of biomedical researchers. As funding declines, and with it, graduate student enrollment, many institutions may lack the critical mass of students and research opportunities to provide optimal training. This will tend to lead to a further concentration of graduate training in a few major research institutions.

QUESTIONS FACING MEDICAL SCHOOLS

This changed environment presents two sets of questions to the medical schools. First, how will these changes affect individual medical schools, and how will they adapt? Specifically, how will they attract and retain qualified faculty? How will they deal with faculty who lose research funding-- both tenured and non tenured faculty? How will they maintain a quality education for students and fellows in the face of lost training grants and key faculty? To what extent will the quality of undergraduate medical education be jeopardized? If graduate programs must be cut, how can this be accomplished most appropriately? How will schools deal with graduate students and post-docs still "in the pipeline?" Finally, how will institutions cover the substantial overhead on their research facilities, or update obsolete equipment?

The second set of questions is how should the medical schools as a group respond to the shared responsibility forpreserving the progress in biomedical research? What actions can be taken to stabilize funding? Should available funds be spread over many researchers or further concentrated in selected centers? As departments begin to discontinue graduate programs, who will ensure that no single field absorbs most of the losses?

Current Trends in Supply/Demand Indicators for Biomedical Science Ph.D.'s

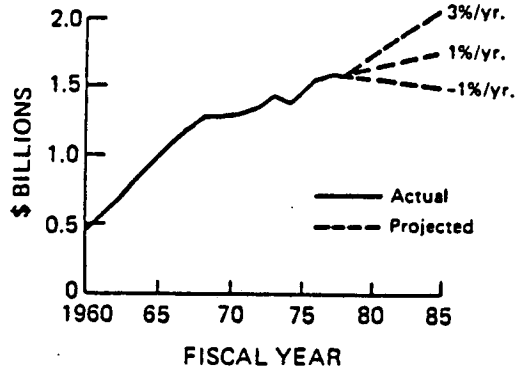
	1973	1975	1976	1977	1978	1979	Annual Growth Rate from 1973 to Latest Year	Latest Annual Change	Average Annual Change from 1973 to Latest Year
1. SUPPLY INDICATORS (New Entrants):									
a. Ph.D. production[a]	3,518	3,516	3,576	3,462	3,512	3,636	0.6%	3.5%	20
b. % of Ph.D.'s without specific employment prospects at time of graduation	6.5%	5.5%	5.3%	6.3%	5.1%	4.5%	-5.9%	-11.8%	-0.3%
c. Postdoctoral appts.[b]	4,123	5,346	N/A	6,342	N/A	7,334	10.1%	7.5%	535
2. DEMAND INDICATORS:									
a. National expenditures for health-related R and D (1972 $, bil.)	$3,53	$3.69	$3.80	$3.96	$4.11	$4.29	3.2%	4.4%	$0.127
b. Life science R and D expenditures in colleges and universities (1972 $, bil.)	$1.45	$1.49	$1.57	$1.60	$1.67	N/A	2.9%	4.4%	$0.044
c. NIH research grant expenditures (1972 $, bil.)	$0.792	$0.897	$0.944	$1.00	$1.06	$1.17	6.7%	10.4%	$0.063
3. LABOR FORCE:[b]									
a. Total	43,618	50,585	N/A	55,060	N/A	62,450	6.2%	6.5%	3,139
b. Academic (excl. postdocs.)	24,940	28,563	N/A	30,568	N/A	33,980	5.3%	5.4%	1,507
c. Business	5,328	6,779	N/A	7,002	N/A	8,550	8.2%	10.5%	537
d. Government	4,660	5,083	N/A	5,130	N/A	5,493	2.8%	3.5%	139
e. Non-profit	2,849	3,265	N/A	3,989	N/A	4,805	9.1%	9.8%	326
f. Self-employed	515	841	N/A	863	N/A	1,192	15.0%	17.5%	113
g. Other (incl. postdocs.)	4,913	5,527	N/A	6,715	N/A	7,748	7.9%	7.4%	472
h. Unemployed and seeking	413	527	N/A	793	N/A	682	8.7%	-7.3%	45
4. BIOMEDICAL ENROLLMENTS:[b]									
a. First-year graduate	17,511	18,876	18,756	18,073	N/A	17,487	0.0%	-1.6%	-4
b. Total graduate	34,888	38,314	39,322	39,260	N/A	41,739	3.0%	3.1%	1,142
c. Medical and dental schools	65,922	74,220	77,011	78,289		84,933	4.3%	4.3%	3,169
d. Estimated undergraduate[c]	379,268	424,539	439,946	425,863	N/A	N/A	2.9%	-3.2%	11,649
e. Total biomedical graduate and undergraduate enrollment	480,078	537,073	556,279	543,412	N/A	N/A	3.1%	-2.3%	15,834

[a]Foreign nationals who received their doctorates from U.S. universities are included.

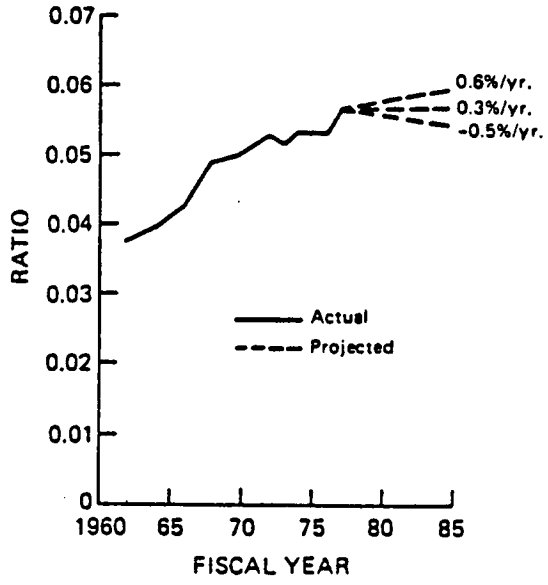
[b]Since labor force and graduate enrollment data are not available for 1978, latest annual change represents average annual growth rate from 1977-79. Graduate enrollment data for 1979 use the "biological science" category defined by the U.S. Department of Education which is a slightly different set of fields from the Committee's definition. Foreign nationals who received their doctorates from U.S. universities are included in labor force data.

[c]Estimated by the formula $U_i = (A_{i+2}/B_{i+2})C_i$ where U_i = biomedical science undergraduate enrollments in year i; A_{i+2} = biomedical B.A. degrees granted in year i+2, excluding health profession B.A.'s; B_{i+2} = total B.A. degrees granted in year i+2; C_i = total undergraduate enrollments in year i.

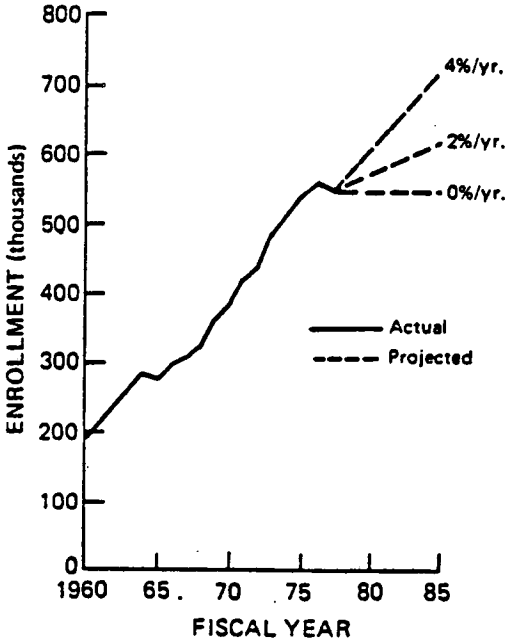
SOURCES: American Dental Association (1971-79a), AMA (1960-80), NIH (1966-81), NRC (1958-80, 1973-80), NSF (1975-79), U.S. Department of Education (1948-81, 1959-79, 1961-79, 1973-77, 1974-80).



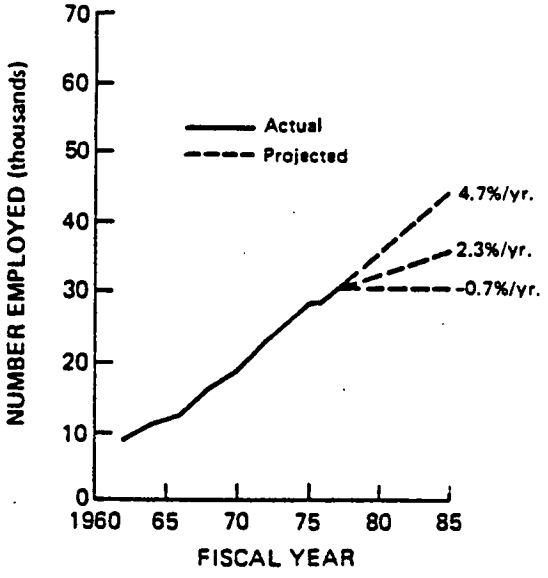
(a) Life Science R and D Expenditures in Colleges and Universities (1972 $)



(b) Biomedical Ph.D. Faculty/Student Ratio



(c) Total Biomedical Graduate and Undergraduate Enrollment



(d) Biomedical Ph.D. Faculty

Life science R and D expenditures, academic employment, and biomedical science enrollment, 1960-77, with projections to 1985. Projections are stated in terms of expected annual growth rates for high, middle, and low estimates.

Figure 1

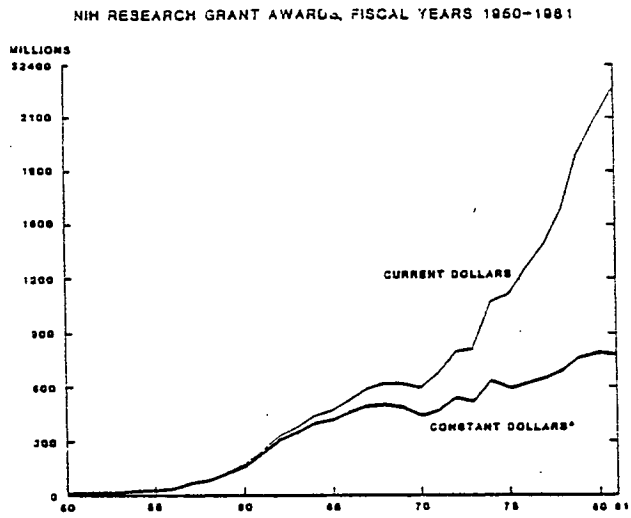
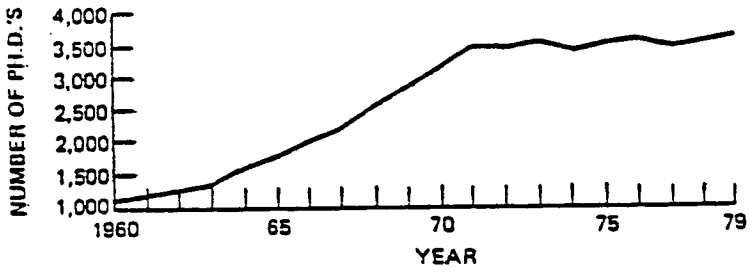
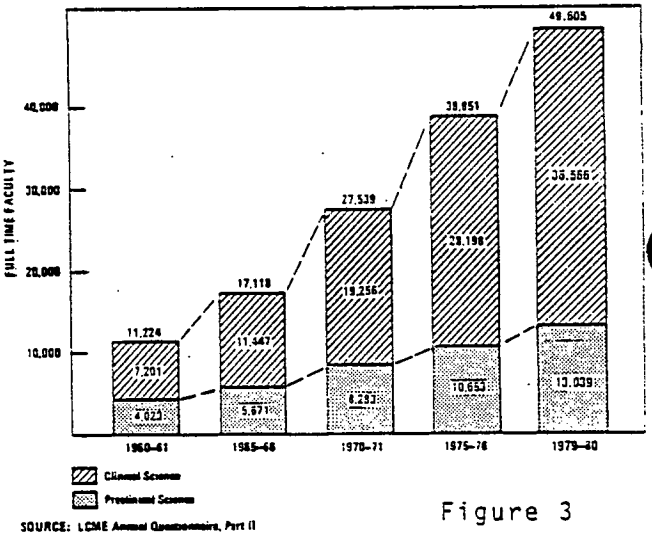


Figure 2



Ph.D.'s Awarded Annually in Biomedical Sciences, 1960-79.

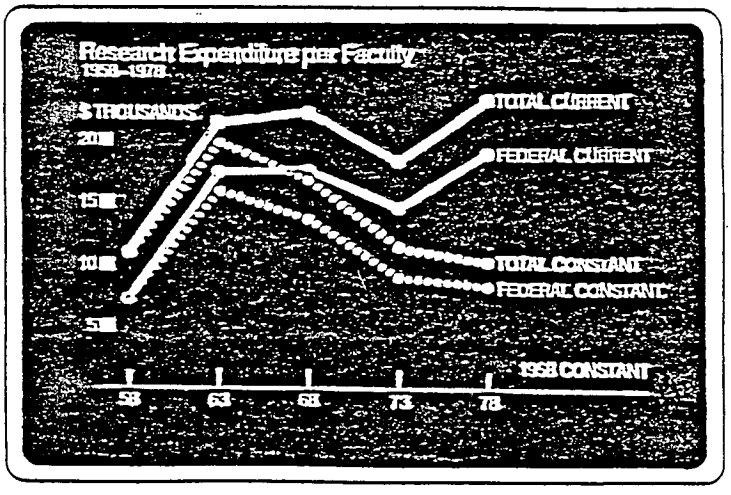
NUMBER OF FULL-TIME FACULTY IN MEDICAL SCHOOLS
1960–61 THROUGH 1979–80



SOURCE: LCME Annual Questionnaire, Part II

Figure 3

Figure 4



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM#82-55 October 12, 1982

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals

FROM: John A. D. Cooper, M.D., President

SUBJECT: AAMC Response to Enactment of the Small Business Innovation Development Act

President Reagan has signed into law, P.L. 97-219, "The Small Business Innovation Development Act of 1982". When fully phased-in by 1986, the mandated Small Business Innovation Research (SBIR) program at NIH will be supported by a set-aside of approximately $40 million. Enactment of this law was strenuously opposed by the academic community, particularly the AAMC, principally on the ground that it is bad public policy to abandon the approach of awarding research and development funds solely on the basis of merit determined through a system of open competition involving expert review of proposals. As a Washington Post Editorial observes, this law "award[s] small business something it cannot secure through the competitive procurement process---a guaranteed share of federal research and development funds." Faced with the enactment of the law, many AAMC members are considering whether it is possible, consistent with their own missions and objectives, and in conformity with the law, to develop organizational forms which would not be foreclosed from participating in the SBIR program. Speculation regarding other avenues for academic participation in SBIR programs is also current. In response to repeated requests for information and/or advice for these deliberations, the AAMC staff has drafted the enclosed paper. Its purpose is to identify and throw light on the relevant issues.

"THE SMALL BUSINESS INNOVATION DEVELOPMENT ACT": CONSIDERATION FOR ACADEMIC MEDICAL CENTERS

On July 22nd, President Reagan signed into law, P.L. 97-219, "The Small Business Innovation Development Act of 1982". This paper is designed to identify issues which must be considered as members of the academic community explore the potential for academic participation in the Small Business Innovation Research (SBIR) programs mandated by the act. No recommendations are offered. Rather, the structure of the SBIR programs is described; the feasibility of academic participation, including some characteristics of eligibility under the definition of small business, is considered; some of the policy considerations involved are discussed; and potential political implications are explored.

The Structure of SBIR Programs

"The Small Business Innovation Development Act" mandates, *inter alia*, the establishment of SBIR programs in both NIH and ADAMHA. These R&D award programs, open only to small business concerns, will be supported by set-asides from the extramural R&D funds of each agency that will gradually increase from 0.2 percent in the first year to 1.25% in the fourth and all subsequent years. (By 1986, for the NIH, this will amount to a set-aside of approximately $40 million). The programs will terminate after six years unless the act is renewed. By statute, each agency's SBIR program is to have three phases: phase one, involving awards made to determine the scientific and technical merit and feasibility of ideas; phase two, involving further development of a limited number of meritorious and feasible phase one awards, with special consideration given to proposals with assured non-Federal capital commitments for the third phase; and phase three involving pursuit of the commercial application of phase two endeavors, principally through use of non-Federal capital, but not excluding the possibility of non-SBIR follow-on Federal contracts.

The Small Business Administration (SBA) is charged with the responsibility for issuing policy directives for the general conduct of SBIR programs. The directives, to be issued by November 19th, will provide for standardized solicitations and funding processes, the latter to cover items such as proposal review, protection of proprietary information, rights in data, and cost principles. However, although charged with the responsibility for issuing such directives, the SBA may leave the writing of regulations up to each agency.

The categories of projects to be included in the SBIR programs will be determined by the individual agencies.

Feasibility of Academic Participation

Issues regarding the feasibility of academic participation in SBIR programs basically fall into three categories: the creation of small business spin-offs; the establishment of a qualified small business; and academic cooperation with firms receiving SBIR awards. Each is discussed in turn below.

Spin-offs

The first consideration is whether a university, a medical school, a teaching hospital, or sub-unit of one of these organizations such as a department or division, can itself become a small business concern for the purpose of participating in the SBIR program, or whether it can do so through such devices as the organization of controlled subsidiary entities. The conclusion is straightforward and negative. The law and regulations are quite explicit that, in order to be eligible, the small business must be independently owned and operated. This is not to say however, that academic institutions are precluded from having an interest in an independent small business. The threshold question thus becomes what extent of academic (or other outside) interest eclipses the requirement that eligible small firms be independent. The answer centers on the somewhat murky issue of control and is discussed further below with regard to the establishment of qualified small businesses.

Establishment of a Qualified Small Business

A member organization might, under certain circumstances, determine that it is in its best interest to encourage and facilitate members of its faculties or staffs to organize an independently owned and operated concern which would be eligible to participate. Such a determination would be based in part on the interests and capabilities of the employee, the coincidence of these capabilities with the programmatic objectives of the federal agencies' SBIR programs, and the conclusion that such an independent organization would, on balance, be in the best interest of the academic institution or hospital.

The organizational requirements for firms eligible for SBIR funds are already substantially set by the Small Business Act and its attendent regulations, since eligibility is limited to small business concerns. While the definition of what constitutes such an entity for purposes of the SBIR program may be refined by future SBA directives, the term is defined in the Small Business Act as follows:

> "Sec 3. For the purpose of this Act, a small business concern shall be deemed to be one which is independently owned and operated and which is not dominant in its field of operation. In addition to the foregoing criteria, the Administrator, in making a detailed definition, may use these criteria, among others: Number of employees, and dollar volume of business. Where the number of employees

> is used as one of the criteria in making such definition for any of the purposes of this Act, the maximum number of employees that a small business concern may have under the definition shall vary from industry to industry to the extent necessary to reflect differing characteristics of such industries and to take proper account of other relevant factors."

We are informed by the SBA staff that their intention is to use as their principal criterion the number of employees of the organization and to set this standard consistent with that used for government contracts and referred to in the patent regulations, namely, 500 or fewer employees.

The key requirement in the statutory definition is that the concern be independently owned and operated. This standard is the subject of substantial discussion in the regulations. In short, the regulations are designed to assure that the concern is not controlled by an affiliated organization or by a third party. "Every business concern is considered as having one or more parties who directly or indirectly control or have the power to control it. Control may be affirmative or negative and it is immaterial whether it is exercised so long as the power to control exists." The regulations specify that in making such determinations "consideration shall be given to all appropriate factors including common ownership, common management and contractual relations".

Subsequent to these general prescriptions, an array of mechanisms of control is identified and described in detail. Two of the less obvious examples of circumstances where control by another organization might be found are included here for purposes of illustration:

> "(b) Common facilities. One concern shares common office space and/or employees and/or other facilities with another concern particularly where such concerns are in the same or related industry or field of operation, or where such concerns were formerly affiliated."

> "(vii) Control through contractual relationships--(a) definition of a joint venture for size determination purposes. A joint venture, for size determination purposes is an association of persons or concerns with interest in any degree or proportion by way of contract, express or implied, consorting to engage in and carry out a single business venture, such as a Government contract, for joint profit for which purpose they combine their efforts, property, money, skill, or knowledge, but without creating a corporation or partnership in the legal or technical sense of the term."

The question is sometimes raised as to whether, in order to be a small business, an entity must be organized for profit. The answer is yes. The Small Business Act defines its scope as dealing with "small business concerns" and the regulations define concerns as follows:

> "(i) 'Concern' means any business entity organized for profit (even if its ownership is in the hands of a non-profit entity) with a place of business located in the United States and which makes a significant contribution to the U.S. economy through payment of taxes and/or use of American products, material and/or labor, etc. 'Concern' includes but is not limited to an individual, partnership, corporation, joint venture, association, or cooperative. For the purpose of making affiliation findings (see paragraph (a) of this section) any business entity, whether organized for profit or not, and any foreign business entity, i.e., any entity located outside the United States, shall be included.

Finally, it should be pointed out that the Small Business Administration has the duty and the power to determine whether any particular firm, person, corporation, partnership cooperative or other business enterprise is a small business for purposes of the Act. [SBA Sec. 8(b)(6)].

From this discussion, it should be clear that the rules of eligibility are already quite specific, and through additional SBA guidance and agency regulations, they are likely to become more so. Any concern or organization meeting the eligibility criteria is likely to be viewed as a welcome participant in SBIR programs by the agencies, although, as indicated later, congressional reaction may be mixed. The concern's antecedents in an academic institution or hospital should in no sense be viewed as disqualifying.

Academic-Small Business Cooperation

While academic medical centers cannot directly pursue awards from SBIR programs, the SBIR programs of the NIH and ADAMHA could provide additional opportunities for university-industry cooperation. The experience of the National Science Foundation SBIR program, on which the legislation is based, is illustrative. The NSF indicates that about one-half of the awards made under their SBIR program involve "coupling" between the small business recipient and a university. The coupling typically takes one of three forms:

- The most frequent involves the use of university scientists and engineers as consultants;
- some small firms have subcontracted parts of their projects to universities; and
- arrangements have also been made for the use of university facilities by SBIR award recipients.

It should be noted that none of these activities is of the nature of a "joint venture" in which initiative and control resides in both parties. While the soon to be issued Small Business Administration policy directives are not likely to explicitly encourage or discourage

university-industry cooperation on SBIR projects, these directives are expected to insure that firms receiving SBIR awards retain primary control over the funded project. Again, the NSF experience is illustrative, although it should not be taken as a determining precedent. The NSF SBIR program requires that, at the time of the award and during the conduct of the proposed research, the principal investor must be primarily employed with the small business; primary employment is defined as 50% of earned income. NSF also requires that the majority of work be performed by the small business recipient. Similar stipulations may well be included in the policy directives or in the regulations governing the NIH and ADAMHA SBIR programs.

Consequently, contrary to what might be implied by a recent Coopers & Lybrand Higher Education Management Alert, opportunities for academic initiative, in SBIR programs (as opposed to cooperation on projects) will probably be limited. The extent of "coupling" that occurs is more likely to be determined by the degree to which small firms seek academic expertise and the responsiveness of schools to such overtures, than by schools initiating offers to collaborate.

Policy Considerations

A wide array of increasingly familiar policy considerations arise in conjunction with each of the possible avenues for academic participation in SBIR programs. The statement which emerged from the March 1982 Pajaro Dunes Conference (The Chronicle of Higher Education, April 7, 1982, Vol. XXIV, Num. 6) provides one of the more thoughtful discussions of the issues involved in relationships between industry and academe. Briefly, some of the considerations are as follows:

Institutional Equity Interest in Small Firms

Institutional interest in corporate research could provide additional revenue for educational endeavors and academically based research activities. However, to the extent that the equity interests of medical schools or universities create a sense of competition between the academic and corporate sectors, the willingness of industry to contribute to academic research efforts may decrease. Further, if the equity interest of the school is in a firm in which members of the school's faculty or staff also have a financial stake, the potential for conflicts of interest to arise (professors as faculty v. professors as employees; professors who are employees--- favored or disfavored---vis a vis professors who are not; professors as employees of competing firms; etc) is likely. The possibility of adverse effects on the morale of the institution is apparent.

Extra-Institutional Research Activities

Undoubtedly, some faculty and staff members may show an interest in trying to take advantage of the availability of small business

set-aside funds. To the extent that faculty scientists act as consultants to or accept subcontracts from small business research enterprises, such activity will be within a long standing and fully sanctioned, although not entirely unproblematic, tradition. However, if the participation involves the conduct of research for a company in which the faculty member has a proprietary or equity interest, a panoply of concerns must be considered. (It should be noted here that, as indicated above, it is entirely possible that the policy directives and regulations for SBIR programs will place restrictions on the primary employment of principal investigators of SBIR projects. In that event, the issues noted below will only come into play with regard to the activities of part-time faculty because full-time faculty will be precluded from participating in SBIR programs as main characters).

The potential benefits to academic medical centers of faculty participation in such extra-institutional research include the following:

1. Extra-institutional research creates a vehicle for academically-based scientists to contribute to applied science and the commercial innovative process and consequently to enhance the health and productivity of society.

2. Faculty participation in commercial research fosters university/industry relationships that could:

   - improve employment opportunities for graduate students and post-doctoral fellows;
   - provide access to superior equipment and facilities; and
   - lead to new sources of revenue, such as industrially-sponsored research and the leasing of surplus institutional facilities and equipment.

3. Industrial activity could provide a productive outlet for investigators who would not otherwise be utilizing their full research capability. As such, it could provide a stop-gap for individuals who are primarily academic scientists and yet are temporarily not receiving research support from other sources.

4. The additional compensation earned by faculty in their external activities would supplement that from their academic appointments, making academic employment more competitive with alternative opportunities. This, in turn, would contribute to improving academic institution's ability to recruit and retain investigators.

However, potential conflicts of interest are readily discernible from faculty involvement in extra-institutional research. Problems thus created probably become greater as the fraction of effort devoted

to external activities increases. These appear to include the following:

1. Realignment of loyalty and orientation can weaken institutional integrity.

   - The diversion of energy to commercial activities could lessen attention and commitment to teaching and academic research.

   - The independent sources of support may weaken authority of department chairmen and deans.

2. Conflicts of interest may also distort traditional academic values, and erode the role of the academy as a retreat for independent study.

   - The credibility of reported research results may be impaired when it is disclosed that the investigator has an economic stake in the results.

   - Potential monetary gain from commercial research activities could conceivably prejudice faculty choice of scientific questions pursued in related academically-based research.

   - Scientific progress might be impeded by interference with the free flow of information, should entreprenuerial considerations occasion suppression of, or unreasonable delays in, publication, or discourage open communication about on-going research.

Small Business-Sponsored Research

As noted above, although consulting and subcontracting arrangements with industry are more traditional and certainly generally healthy forms of university-industry cooperation, these too are not entirely problem free. While many of the positive considerations raised by extra-institutional research activities such as the enhancement of innovation, and creation of new sources of revenue also hold true for industry-sponsored research, so do some of the more negative concerns such as secrecy and the diversion of energy from academic research.

Potential Political Implications

Aside from the considerations discussed above, other possible implications from academic participation in SBIR programs are conceivable. Congressional reaction to faculty participation in SBIR programs is likely to be mixed. While some sponsors of the now enacted set-aside legislation expect and look forward to seeing academic scientists wooed away from their "Ivory Towers", many members of

Congress, particularly those on the House committee with jurisdiction over the NIH and ADAMHA, who actively worked to exempt those agencies, can be expected to view askance the establishment of profit-making research ventures by academic scientists. During the House debate, opponents of the bill predicted that the legislation would cause academic scientists to set up private businesses across the street from their institutions where the same work would be conducted, often by the same people, at a higher cost to government. Further, the "commercialization of academic research" has recently become the subject of on-going congressional investigation. In light of this, and because the controversial nature of the legislation ensures close oversight of its implementation, the role of academic institutions in implementation of the Act is not likely to escape scrutiny and could arouse congressional criticism. Moreover, because of their vocal opposition to the legislation, active pursuit of SBIR funds by academic medical centers or the members of the faculties of such institutions could raise questions on Capitol Hill about the integrity of the voice of academic medicine.

Faculty participation in SBIR programs could be expected to improve significantly both the scientific and technical merit of SBIR proposals. Ironically, this could provide an illusory record of success and improve the chances for renewal of the Act in 1988.

cc: Principal Business Officers

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University of Arkansas	*Thomas A. Bruce*	
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University of California - L.A.	*Sherman M. Mellinkoff*	
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CMDNJ - Rutgers Medical School	*Richard C. Reynolds*	
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