

COUNCIL OF DEANS and COUNCIL OF ACADEMIC SOCIETIES
JOINT ADMINISTRATIVE BOARDS MEETING
 Wednesday, June 15, 1994, 2:00-3:30 p.m.
 Roosevelt Room, ANA Hotel

AGENDA

- I. Call to Order
- II. Executive Council Discussion Items [see Executive Council tab]
 - A. Health Care Reform Update and Issues F
 - The Kennedy Bill
 - B. Indirect Cost Update and Issues
 - C. Update on Ad Hoc Group for Medical Research Funding
 - D. Harkin/Hatfield Trust Fund Proposal

COUNCIL OF DEANS ADMINISTRATIVE BOARD MEETING
 Wednesday, June 15, 1994, 4:00-5:30 p.m.
 Thursday, June 16, 1994, 9:00 a.m.-12:00 noon
 Decatur Room, ANA Hotel

AGENDA

- I. EXECUTIVE SESSION (4:00-4:45 p.m.)
- II. Report of the Chair
- III. Consideration of the Minutes [see COD Minutes tab]
 - February 23-24, 1994 1
 - April 18, 1994 15
- IV. Executive Council Action Items [see Executive Council tab]
 - A. ERAS C
 - B. Section on Resident Education D
 - C. ACGME Bylaws E
 - D. Data Release Policy G
 - E. Advisory Panel on Mission and Organization
of Medical Schools H
- V. Council of Deans Action/Discussion Items [see COD Action/Discussion Items tab]
 - A. Study Group on Development of COD
Mission Statement 1
 - B. Study Group on the Role of Medical
Schools in Graduate Medical Education 4
 - C. Council of Deans Program at 1994 Annual Meeting 8
 - D. Deans' Survey on the Financial Impact of
Health Care Reform on Medical Schools 10
 - E. Site and Dates for 1997 Spring Meeting 15
 - F. Minority Health Improvement Act 16

VI. Organization of Resident Representatives Report

VII. Organization of Student Representatives Report

VIII. Information Items

[see Executive Council tab]

A. LCME Accreditation Actions I

B. Group Progress Reports J

[see COD Information Items tab]

C. Reports on Small Group Discussion Sessions at
1994 COD Spring Meeting 1

1. Recruitment, Training and Retention of
Clinician Scientists 2

2. The Impact of Managed Care Systems 3

3. Integration of Practice Plans and Multi-Specialty
Group Plans 5

4. Health Outcomes/Quality Research 6

5. Primary Care Curriculum and the Education of
Generalist Physicians 8

IX. Old/New Business

X. Adjournment

COUNCIL OF DEANS ADMINISTRATIVE BOARD

JUNE 15-16, 1994
ANA HOTEL AND AAMC HEADQUARTERS

SCHEDULE and LOCATION OF MEETINGS

Wednesday, June 15

Location

2:00 - 3:30 p.m.
Joint Session with Council of Academic Societies

Roosevelt

4:00 - 4:45 p.m.
COD Administrative Board *Executive Session*
4:45 - 5:30 P.M.
COD Administrative Board Meeting

Decatur

6:30 - 7:30 p.m.
Joint Boards Session (speaker to be announced)

Executive Forum

7:30 p.m.
Joint Boards Reception and Dinner

Ballroom Foyer and Ballroom I

Thursday, June 17

7:30 - 8:30 a.m.
Joint Boards Breakfast
Speaker: Dr. Andrew Wallace, Chairman, ERAS Advisory Committee

Roosevelt

9:00 a.m. - Noon
COD Administrative Board Meeting

Decatur

12:00 - 2:00 p.m.
Joint Boards Lunch
Speaker: Bruce Vladeck, Administrator, Health Care Financing
Administration

Roosevelt

2:00 - 4:00 p.m.
Executive Council Meeting

AAMC Conference Room 130

COUNCIL OF DEANS ADMINISTRATIVE BOARD MEETING
February 23-24, 1994
Washington, D.C.

JOINT MEETING OF THE ADMINISTRATIVE BOARDS
OF THE COUNCIL OF DEANS and COUNCIL OF TEACHING HOSPITALS
Wednesday, February 23, 1994

EXECUTIVE SESSION

The joint Administrative Boards met in Executive Session.
Attendees from the COD Administrative Board were:

Executive Council Represent-
tatives

George T. Bryan, M.D.,
Chair, *presiding*
Harry N. Beaty, M.D.
Richard A. Cooper, M.D.
Charles H. Epps, Jr., M.D.
Herbert Pardes, M.D.
William A. Peck, M.D.
I. Dodd Wilson, M.D.

Members At Large

Robert M. Daugherty, Jr., M.D.,
Ph.D.
Philip J. Fialkow, M.D.
John J. Hutton, M.D.

Members Absent

James A. Hallock, M.D.
Michael M.E. Johns, M.D.

Also attending were members of the AAMC Executive Committee and senior Association staff.

COUNCIL OF DEANS ADMINISTRATIVE BOARD MEETING
Thursday, February 24, 1994

Members Present

Executive Council
Representatives

George T. Bryan, M.D.,
Chair, *presiding*
Harry N. Beaty, M.D.
Richard A. Cooper, M.D.
Charles H. Epps, Jr., M.D.
James A. Hallock, M.D.
Herbert Pardes, M.D.
William A. Peck, M.D.
I. Dodd Wilson, M.D.

Members At Large

Robert M. Daugherty, Jr., M.D.,
Ph.D.
Philip J. Fialkow, M.D.
John J. Hutton, M.D.

Member Absent

Michael M.E. Johns, M.D.

Guests Present for All or a Part of the Meeting

Stuart Bondurant, M.D.,
Chair, Assembly
C. Kay Clawson, M.D., Dis-
tinguished Service Member
Jordan J. Cohen, President-
designate
Organization of Resident

Representatives

Michele C. Parker, M.D., Chair
Denise Dupras, M.D., Chair- elect

Organization of Student

Representatives

Bruce Weinstein, Chair
Stacy Tessler, Chair-elect

Observer

Harry S. Jonas, M.D. (American
Medical Association)

Staff Present for All or a Part of the Meeting

M. Brownell Anderson	David B. Moore
Robert L. Beran, Ph.D.	Patricia Shea
G. Robert D'Antuono	Edward J. Stemmler, M.D.
Frances R. Hall	Kathleen S. Turner
Donald G. Kassebaum, M.D.	Donna Quinn Yudkin
Joseph A. Keyes, Jr.	Lynn Milas, <i>recording secretary</i>
Richard M. Knapp, Ph.D.	

CALL TO ORDER

Dr. George Bryan called the meeting to order at 8:35 a.m. He welcomed new and returning members of the Administrative Board. Calling their attention to the revised agenda, he advised members that a great many issues needed to be acted upon and that the board should address the more routine items first to allow sufficient time for a discussion of the resolutions on health care reform to be presented at the Executive Council meeting that afternoon.

MINUTES OF THE SEPTEMBER 23-24, 1993, AND NOVEMBER 8, 1993, MEETINGS

Action Upon motion made, seconded and passed, the minutes were approved as written.

COD DISCUSSION ITEMS

Study Group on the Development of a COD Mission Statement

Dr. Bryan reported that his group had met and was considering alternative statements developed by each member and would present a report at the 1994 Spring Meeting.

Study Group on the Role of Medical Schools in Graduate Medical Education

Dr. Richard Cooper reported that the group would meet on the next day, February 25, to discuss physician workforce issues and revisit the generalist physician issue and the current position of the AAMC. Included would be a discussion of consortia. He noted that Drs. Herbert Pardes and James Hallock from the Administrative Board were members of the study group.

Program for 1994 COD Spring Meeting

Dr. Pardes reported that the central focus for the meeting would be academic medicine and health care reform and briefly described the program. He noted that at the traditional dinner on the Tuesday evening of the meeting, some time would be dedicated to honoring Dr. Robert Petersdorf's contribution to the Association.

COD Program for 1994 Annual Meeting

Dr. Bryan announced that he had asked Drs. Hallock, Robert Daugherty and Philip Fialkow to serve as a planning committee to work with Dr. Robert Beran on planning for COD program sessions. Dr. Beran noted that he would call the committee members soon.

White Paper Executive Summary: The Connection Between Continuing Medical Education (CME) and Health Care Reform (HCR)

Action Upon motion made, seconded and passed, the report was accepted for discussion at the June 15-16, 1994, meeting.

Dr. Hallock noted that the Accreditation Council for Continuing Medical Education (ACCME), of whose executive committee he was vice chair, would discuss this at their next meeting and asked that attendees forward any comments to him by March 17.

ORGANIZATION OF STUDENT REPRESENTATIVES REPORT

Mr. Bruce Weinstein reported that current OSR activities included a series of surveys of the OSR membership on a number of issues, including domestic violence education, use of the OSR housing exchange network, and multicultural sensitivity and awareness; publication of a poster to be displayed at medical schools; a determination that the theme of the OSR program at the Annual Meeting would be "holes in the medical school curriculum" to address issues such as domestic violence; and the development of a mission statement for the OSR for presentation at its June 15-16 Administrative Board meeting. He expressed the OSR concern that the Association was retreating from its support of Title VII student loans. Dr. Beran responded that the AAMC had not retreated but had recognized that the Congress would not pass such a program without a primary care service commitment tied to these loans. Dr. Bryan noted that the COD had supported the OSR position and continues to support it. Several suggestions were offered to get past the impasse in the House of Representatives, especially since the sense of the group was that the Senate version had been more amenable to the AAMC viewpoint. It was agreed that the two versions of this legislation should be summarized for the June meeting of the Administrative Board.

ORGANIZATION OF RESIDENT REPRESENTATIVES

Dr. Michele Parker reported that current ORR activities included communications efforts such as developing their newsletter and trying to network with other resident organizations, that they hoped to work with the OSR on issues of student mistreatment and how residents can be better teachers and avoid any mistreatment of students, and that they would like to revisit the document on resident working hours, benefits and annual leave policies in terms of health care reform, especially if residency programs are condensed. She noted that a preliminary theme for ORR Sessions at the 1994 Annual Meeting is how education will be changing in the setting of managed care and will include a speaker to give a historical perspective.

EXECUTIVE COUNCIL ACTION/DISCUSSION ITEMS

Council of Teaching Hospitals Membership

The COD Administrative Board had no objection to the approval of the application of the New Orleans Adolescent Hospital for COTH membership.

Accreditation Council for Graduate Medical Education Bylaws

Action Upon motion made, seconded and passed, the COD Administrative Board endorsed the recommendation that the Executive Council approve the proposed Bylaws change.

Accreditation Council for Graduate Medical Education General Requirements

Mr. Weinstein reported that the OSR feels that the security issues dealt with in the proposed change are very important and although it does not object to the recommendation that the Executive Council take no action, it would like the COD and the AAMC to pursue the issue through the AAMC's representatives on the ACGME. A board member remarked that he thought the proposed revision was too detailed for general requirements. No action was taken.

ORR Bylaws

Dr. Beran reported that the ORR membership had approved the proposed amendment at its meeting in November 1993. The amendment was a proposed change in Section 3 (Membership) which would add the following paragraph:

To the extent that a specialty recognized by the ACGME with accredited residency training programs is not represented on the ORR by either a CAS member program director or clinical chair group, a member society may submit a letter of interest to the ORR stating a desire to designate a (one) resident physician to the ORR. Upon approval by the ORR administrative board and Executive Council of the AAMC, the society will be asked to forward the name of the resident physician the society wishes to designate.

Action Upon motion made, seconded and passed, the COD Administrative Board endorsed the recommendation to amend the ORR Bylaws.

Electronic Residency Application Service Executive Summary and Report

Action Upon motion made, seconded and passed, the COD Administrative Board accepted the Executive Summary and Report of the ERAS Advisory Committee for discussion at the June 15-16, 1994, meeting.

Interim Position Statement on the Medical Direction of Residents by Teaching Physicians

Action Upon motion made, seconded and passed, the COD Administrative Board endorsed the recommendation that this statement be approved by the Executive Council.

Designation of AAMC President Emeritus

Action There was a unanimous declaration of the COD Administrative Board's endorsement of the recommendation that Robert G. Petersdorf be awarded the title of President Emeritus effective April 1, 1994.

Proposal to Form a Group on Resident and Clinical Affairs

Mr. Robert D'Antuono presented the proposal, noting that the rationale for an independent group was to foster relationships between medical education directors and vice presidents for clinical affairs at hospitals and academic medical centers. He noted that the new group would maintain liaison with the Group on Educational Affairs. Ms. Brownell Anderson noted that the SRE has brought to the Association a constituency that had not previously been involved and who were very enthusiastic about the AAMC and that there had been increased interest in membership in the GEA as a result. She remarked that overall the establishment of this group had been a positive experience for the GEA.

Members of the Administrative Board commented that they thought the new name was confusing since they had thought it referred to a different purpose at the hospitals and medical centers. There was also comment that fostering a separate group with an agenda different from education was in contrast to other efforts of the Association to have all aspects of medical education recognized as a continuum rather than discrete elements. Dr. Edward Stemmler acknowledged this goal but noted the positive aspects of bringing this group into the Association and noted that the proposal to form the group was constituent-driven.

The consensus was to accept the report for further discussion at the June 15-16, 1994, meeting.

Health Care Reform Report

Dr. Bryan observed that the discussion would be a reprise of the Joint Meeting of the COD and COTH Administrative Boards held the previous day. He pointed out the two draft resolutions for the Administrative Board's consideration and noted that they would be presented at the Executive Council meeting that afternoon. [The resolutions are attached to these minutes as Attachment 1 ("Education") and Attachment 2 ("Financing").]

He thanked Drs. Pardes, Daugherty, John Hutton, Dodd Wilson and Stemmler and Mr. Joseph Keyes who had worked diligently through the night with members of the COTH Administrative Board and other staff to produce the two resolutions. He noted that the Administrative Boards were asked to review the resolutions to assure that they reflect the intent of the Association and not to concentrate on specific language.

It was noted that these resolutions were a change of position for the AAMC and that they should be accepted as statements of principle and not be burdened with technical language so that they

can be generalizable to whatever form health care reform legislation may take.

Dr. Pardes prefaced his remarks by expressing appreciation for the candor and willingness to consider the well being of medical schools shown by the COTH Administrative Board members who, while not presuming to speak for all of their constituents, worked very hard to produce a document their members could fully support. He also acknowledged the role of the staff during the discussions to advise the members on what was politically feasible.

Considerable discussion followed of various points in the two resolutions which included the following points:

"Education Resolution"

- The deans should recognize the support this document has received from the COTH Administrative Board in stating that the core mission of medical schools is education and that the COTH will accept this entire document which is a revision of the resolution passed at the Council of Deans Business Meeting on November 8, 1993.
- There was discussion of the word *ideally* and although some Administrative Board members desired to remove the word since it qualified the endorsement, they recognized that the use of the word was a compromise with the COTH Administrative Board.
- There was also discussion on the fact that the "musts" of the COD Business Meeting resolution had been replaced by "shoulds" in the set of objectives. This was done to state that consortia were voluntary in recognition of the diversity of the nation's medical schools and to assure support by the entire AAMC constituency for an AAMC position.

Action Upon motion made, seconded and unanimously passed, the COD Administrative Board recommends that the Executive Council approve the resolution setting forth the statement of principles affirming that education is the core mission of the medical schools. However, if acceptable to other Executive Council members, the words *ideally* and *should* should be replaced with less ambiguous language affirming the centrality of the medical schools to consortia.

"Financing Resolution"

- First Bullet: Rather than recognizing "unique medical school needs," it was suggested that substitute language be used, such as "support the unique mission of medical schools as vital components of an academic health center," since the phrase *academic health center* is used throughout the Clinton Administration's Health Security Act (HSA). This was opposed since it goes to the philosophical question of whether medical education should be university-based or practice-based. Although the reality of the relationship between many medical schools and academic health centers was acknowledged, the point here was to focus on the COD constituency. It was argued,

however, that by stressing medical schools and thus identifying a specific entity within the academic health center, there is risk that other components of such centers (such as nursing schools, physician assistants training programs, pharmacy schools, etc.) will also want to be identified as recipients of the "education fund," which could result in its being split among many rather than leaving it to the academic health center which is a general enough concept to permit some individual differences in how the various components are funded. This was countered with the observation that if "academic health centers" are to receive all the funding, then every hospital with even a tenuous affiliation to a medical school will become overnight an "academic health center," that this terminology would confuse and debase the term, and this strategy would therefore accomplish exactly the opposite of what the COD wants, which is a separate rationale and a separate fund to protect the medical schools. It was noted that the HSA devotes very little attention to medical education of any sort, so that the strategy of pursuing "education" as a rationale would probably not be viable and that the patient care aspects of medical training should be stressed. It was pointed out that fewer than half of the organizations that own a hospital also own the medical school affiliated with the hospital.

It was generally agreed that funding be identified as the need of the medical schools being addressed in the first bullet.

It was suggested that language be included addressing the current financial constraints facing medical schools but the reasoning was accepted that since this is a statement of principle and not intended as a document for legislators, such language would overly encumber the document.

- Third Bullet: Replace the word *vigorously* with *actively* since this wording indicates that the Association will determine how the studies should be conducted. It was noted that congressmen had requested that AAMC "vigorously" pursue these studies. The deadline for having studies completed is shown as January 1, 1996, which was perceived as too long a time period for such work. It was suggested that June 1, 1995 be the deadline because that is prior to the fiscal year which includes the start of the proposed fund for medical education (January 1, 1996) and would enable the Association's Administrative Boards time to comment on the studies at the June and September meetings that year. It was pointed out that there would be no argument with completing such a study before the January 1, 1996, deadline and that the whole intent of the bullet is that the Association would begin advocating immediately for funds that will be available on January 1, 1996. The timing was seen by some as even shorter than this and it was suggested that the AAMC work very hard to produce numbers within the next several months to insure that such funding is included in the current

legislation. It was agreed that the AAMC would work to accomplish such studies as soon as possible.

- Fifth Bullet: Everything following the first sentence should be deleted because this was not specifically discussed at the meeting. The deans recognize that IME money is meant to reimburse hospitals, but they would insist on an incremental stream of money which could be used to support academic medicine. It was argued, however, that the rationale for including the additional sentences is to reassure hospital directors that medical schools would not advocate for funds that had been traditionally directed to hospitals. It was suggested that the last sentence be replaced with one that links the academic health center concept (and the academic health center fund in the HSA) to the notion that such a fund may include a number of ingredients in medical education.

Proposed was the following language after the first sentence: "The AAMC should assure that its advocacy for medical school support is in parallel with its advocacy on behalf of other facets of academic medicine, including teaching hospitals and research. Specifically, this advocacy should go hand in hand with AAMC advocacy for IME and DME monies based on pre-existing rationale."

The HSA confused the two funding sources and did not demonstrate a knowledge of how medical education is subsidized by practice income. The AAMC should make certain that this is clarified in the HSA. There is a general confusion in various governmental bodies because funding which is called one thing ("indirect medical education") seems to be directed toward education but in reality is used to reimburse teaching hospitals for their higher costs. Therefore, governmental people think they are supporting medical schools when actually they are supporting resident education in hospitals. Also noted was the political reality of opposition to increasing IME by some members of Congress. It was recommended that the AAMC develop a set of principles which would be valid in whatever health care reform legislation that is ultimately adopted. As a policy statement for the Association, the term *medical school* should be emphasized throughout the document.

The confusion in the HSA was deliberate in that the term *academic fund* was used to cover both the current IME and other funding to be directed toward education. The concern is that although the Administration may have meant to direct separate funds within the academic fund to the medical schools, if another bill ultimately is passed made up of bits of the various pieces of legislation, this distinction may be completely lost and the result would be only one fund to replace the current IME funding. The medical schools would therefore be left with no funding for education. The deans are insistent that a separate revenue stream directed at the medical schools be clearly delineated so that it is not

lost in the legislative process. The compromise between the COTH and COD Administrative Boards addressed this concern in that it was understood that IME funding was to be directed toward hospitals and that a separate stream of incremental monies was to be identified for the medical schools. Some deans felt that if this distinction in funding sources cannot be accomplished, then the the deans would renew their claim on a part of the single funding source. Another view was that the phrase *incremental dollars* was ambiguous.

It was agreed that the AAMC would argue for two equally valued streams of monies, one for the medical schools and one to help make teaching hospitals more competitive (IME), and that this argument would be made in all proposals of health care reform legislation. Clarifying what the funds are meant to accomplish was stressed, and titles were suggested that would clearly show each fund's purpose, such as "hospital comparability price adjustment" as the successor for the IME and "sustenance for medical schools" as the separate fund for the medical schools.

A writing committee produced a revision of the last bullet which was accepted by the group. It was agreed that the first sentence would remain and that the rest of that paragraph would be struck from this statement of principle. It was additionally agreed that a separate motion for approval by the Executive Council would direct the staff to draft legislative language that would be in the form of a substitute for the current academic health center provision in the Health Security Act and in the circumstance of any other legislative vehicle presenting itself as "health care reform." Such language would have two provisions: (1) create a stream of revenue for teaching hospitals consistent with the current rationale for the Indirect Medical Education (IME) adjustment under the Medicare program and (2) create a separate stream of revenue for medical schools in language that would be consistent with the set of principles incorporated within the document.

Action Upon motion made, seconded and unanimously passed, the COD Administrative Board endorsed for Executive Council approval the following resolutions concerning financing:

Resolution
Council of Deans/Council of Teaching Hospitals

The Council of Deans and The Council of Teaching Hospitals recommend that the AAMC adopt and support the following principles:

- That the AAMC should actively articulate the legitimacy of the need to recognize unique medical school resource needs within the context of health care reform.
- That the AAMC champion the acquisition of incremental dollars for medical schools, within the context of health care reform, to

assure their ability to maintain an appropriate infrastructure and to respond to the requirements of health care reform.

- That the AAMC should both vigorously advocate an external study of these needs and initiate an intensive internal process to study these needs and support the external study effort. These studies should be completed as soon as possible.
- That the AAMC should immediately advocate for a fund to provide support for medical schools. This fund should be viewed and advocated as a fund to provide assistance to medical schools beginning January 1, 1996 pending the completion of, and legislative action on the results of, the internal and external studies. The magnitude of this fund and, within the context of the Health Security Act, its placement within or in addition to existing workforce or academic health center subtitles should be determined by AAMC staff as soon as possible.
- The AAMC should assure that its advocacy for medical school support is in parallel with its advocacy on behalf of other facets of academic medicine.

Resolution
Council of Deans

The staff is directed to develop legislative language, as a substitute for the current Academic Health Center fund in the Health Security Act, and as an addition to any legislative vehicle presented as health care reform, to

- Identify a ^{an all payor} stream of revenue consistent with the current ^{Medicare} rational for the Indirect Medical Education (IME); and,
- Identify a ^{an all payor} stream of revenue to fund the unique financial needs of medical schools.

[The highlighted words were later added at the Executive Council meeting.]

Review of ACGME Discussion Draft: "The Role of the ACGME in Relationship to National Physician Workforce Planning"

Dr. Jordan Cohen, noting his role as Chair of the ACGME Executive Committee and the task force which produced the document, reviewed its background and reported that it was currently being circulated among the five parent organizations of the ACGME. He requested that the AAMC as one of the parents endorse this concept paper to permit the ACGME to move forward to develop a proposal for how it might act on the set of recommendations contained in the paper.

He summarized the principles as (1) the ACGME is not constituted to be the allocation mechanism to analyze workforce needs; (2) in whatever mechanism is adopted to reduce the size of the training

system, that educational quality be a dominant principle in such decisions; and (3) that in consonance with tradition governing medical accreditation decisions, judgments on educational quality be made by the medical profession. He requested that in accordance with these principles, the AAMC approve that the ACGME proceed to develop a system to classify and stratify positions by discipline in terms of quality and that if this process proves to be acceptable that the information derived from this activity be handed over to whatever allocation mechanism develops as a result of health care reform legislation. He observed that such an allocation mechanism, if it ever comes about, would make the actual decisions on using the stratification system. He noted that of the other parents, the Council of Medical Specialty Societies (CMSS) and the American Hospital Association (AHA) have strongly endorsed this concept, and that information had been received that the American Board of Medical Specialties (ABMS) was perceived as favorable. The American Medical Association (AMA) had been resistant, he reported, but it was sensed that there might be a change in their position. He noted that unanimous agreement of the parents was required before the ACGME could undertake such a project.

Dr. Bryan did not participate in the discussion because of his membership in the Council on Graduate Medical Education (CoGME).

Discussion centered on whether there would be any liability for parent organizations in any "quality ranking" done by the ACGME in terms of restraint of trade issues as was the case for the Liaison Committee on Medical Education (LCME). Dr. Cohen assured the group that the ACGME would not proceed without complete indemnification of the ACGME, and noted that indemnifying the parents should be added.

There was discussion of how, in terms of quality ranking, would small, rural health care centers compete with large, urban research university medical centers. Dr. Cohen advised that the ACGME assumption was that the allocation mechanism would take regional needs into account so that programs would not compete on a national basis. Included in this assumption, he noted, would be the needs of underrepresented minorities as well as innovative and small programs. There was consensus that this issue would need to be carefully monitored to make sure that local needs would be considered in such an allocation system. The deans were concerned over "who decides" in such cases, but reaffirmed that educational quality should be the major criterion in a ranking of programs.

Dr. Cohen concluded by thanking the Administrative Board members for their comments and remarking that he thought that any ranking of programs which may result from this system would be strictly advisory on the part of ACGME.

Roles for Medical Education in Health Care Reform

Dr. Donald Kassebaum noted that the proposed position paper is a recommendation of the Advisory Panel on Strategic Positioning for

Health Care Reform and is a statement of issues, problems and unfulfilled recommendations from other bodies about concerns the education establishment should address. He remarked that the Council of Academic Societies (CAS) had endorsed the document with minor editing that would provide the ability to include a definition of generalism that incorporates more specialties than the current definition, should such a definition become accepted.

Action Upon motion made, seconded and passed, the COD Administrative Board endorsed the recommendation that the document as edited be approved by the Executive Council.

The Department of Veterans Affairs and Health Care Reform

Dr. Richard Knapp presented the draft position paper and noted it was developed as a discussion paper that outlines what could happen to the DVA in health care reform and how the AAMC should respond to certain issues. He referred the members specifically to a policy statement which states that the Association's position is based on the needs of the DVA population rather than on educational need and that the paper emphasizes that the needs of the DVA should come before the needs of educational institutions aligned with the DVA.

Concern was expressed that many schools had structured their programs over many years around the DVA facilities in their communities and that reference to this relationship should be made in the document. Others demurred, noting the parallel to the closing of Public Health Service hospitals, and stated that it would not be advisable for the AAMC to put the needs of its member schools before the needs of government agencies allied to those schools.

The consensus was that the issue should be further discussed, but the argument was made that it would be desirable for the Association to issue a position statement and that therefore the decision could not be deferred. It was noted that the proposed position was not inconsistent with previous stated Association policy and it would serve a useful purpose in terms of the AAMC's relationship with the DVA. It was observed that DVA patients were an important stream of patients for some medical schools. It was agreed that language could be incorporated noting the historical partnership of these institutions and the willingness of medical schools to work with the DVA on the mission to strengthen the Department.

Action Upon motion made, seconded and passed, the COD Administrative Board endorsed the recommendation that the Executive Council approve the document with changes as noted.

National Health Research Fund ("Harkin-Hatfield Bill")

Action Upon motion made, seconded and passed, the COD Administrative Board endorsed the recommendation that the Executive Council decide whether to support the Harkin-Hatfield proposal.

ADJOURNMENT

The meeting adjourned at 12:05 p.m.

Resolution
Council of Deans/Council of Teaching Hospitals

The Council of Deans and The Council of Teaching Hospitals recommends that the AAMC affirm:

- A. That education is the core mission of medical schools, and
- B. That undergraduate, graduate and continuing medical education are part of an overall educational continuum and process, and
- C. That medical schools necessarily have a central role in assuring the quality and composition of tomorrow's physician workforce, and
- D. That consortia, as described in the AAMC's July, 1993 position paper on Graduate Medical Education, represent an effective means of accomplishing the tasks and processes required for GME programs of the future.

To facilitate the achievement of these objectives The Council of Deans and The Council of Teaching Hospitals further recommend that the AAMC affirm that ideally:

- A. Consortia should be the focal point for collaborative decision-making and resource allocation and coordination for GME based on needs assessment, and
- B. Consortia should include one or more medical schools as participants, and
- C. Medical schools should provide leadership, in cooperation with their teaching partners, for the GME educational process and product, and
- D. Payments for GME should be made to the organization or entity that incurs these costs or to a designated agent such as a consortia.

Resolution
Council of Deans/Council of Teaching Hospitals

The Council of Deans and The Council of Teaching Hospitals recommend that the AAMC adopt and support the following principles:

- That the AAMC should actively articulate the legitimacy of the need to recognize unique medical school needs within the context of health care reform.
- That the AAMC champion the acquisition of incremental dollars for medical schools, within the context of health care reform, to assure their ability to maintain an appropriate infrastructure and to respond to the requirements of health care reform.
- That the AAMC should both vigorously advocate an external study of these needs and initiate an intensive internal process to study these needs and support the external study effort. These studies should be completed by January 1, 1996 or as soon thereafter as feasible.
- That the AAMC should immediately advocate for a fund to provide support for medical schools. This fund should be viewed and advocated as a fund to provide assistance to medical schools beginning January 1, 1996 pending the completion of, and legislative action on the results of, the internal and external studies. The magnitude of this fund and, within the context of the Health Security Act, its placement within or in addition to existing workforce or academic health center subtitles should be determined by AAMC staff as soon as possible.
- The AAMC should assure that its advocacy for medical school support is in parallel with its advocacy on behalf of other facets of academic medicine. Furthermore, the rationale for medical school support should not be intermingled with the Association's rationale for all payor equivalents of Medicare DME and IME within the context of health care reform legislation. Within the context of the Health Security Act, and these principles, the Association should also seek to clarify that the academic health center fund as currently constituted is fundamentally a replacement for - and an all payor extension of - Medicare IME support.

COUNCIL OF DEANS ADMINISTRATIVE BOARD LUNCHEON MEETING
April 18, 1994
Palm Beach, Florida

Members Present

Executive Council

Representatives

George T. Bryan, M.D.,
Chair, *presiding*
Harry N. Beaty, M.D.
Richard A. Cooper, M.D.
James A. Hallock, M.D.
Michael M.E. Johns, M.D.
Herbert Pardes, M.D.
William A. Peck, M.D.
I. Dodd Wilson, M.D.

Members At Large

Robert M. Daugherty, Jr.,
M.D., Ph.D.
Philip J. Fialkow, M.D.
John J. Hutton, M.D.

Member absent

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

Guest Present

Stuart Bondurant, M.D., Chair,
Assembly

Staff Present

Robert L. Beran, Ph.D.
Jordan J. Cohen, M.D.
Douglas E. Kelly, Ph.D.
Joseph A. Keyes, Jr.
Richard M. Knapp, Ph.D.
Kathleen S. Turner
Lynn Milas, *recording secretary*

CALL TO ORDER

Dr. George Bryan called the meeting to order at 12:20 p.m. He announced that there were five items for the agenda: the members' feedback on the Spring Meeting; an item from Dr. Jordan Cohen; two items from Mr. Joseph Keyes; a report from Dr. James Hallock on plans for the 1994 Annual Meeting; and a report on the status of the COD Mission Statement.

A question arose on scheduling an Administrative Board discussion of the physician workforce issue before the June governance meetings. Some noted that the presentations and town meeting discussion of this issue on the next day's program could result in specific recommendations for the Association which in light of negotiations in the Congress on health care reform should not be delayed, while others commented that this particular issue in the total health care reform legislation was not immediate for the Congress and that such a discussion could be delayed until the June governance meeting. A vote was taken on whether to meet prior to June on this issue and, with the nays prevailing, Dr. Bryan announced that the matter would be addressed at the June meeting.

1994 SPRING MEETING

Dr. Bryan requested the members' perceptions of the meeting. He expressed his appreciation of the planning committee's efforts under Dr. Herbert Pardes' leadership and noted that the sessions were timely and on target and not only provided information to the deans but also allowed them to respond. He expressed his personal delight with the meeting, and comments from other members echoed these sentiments.

Consensus emerged that there was a desire on the part of the deans to have more interaction with the senior staff, that this was especially apparent following Dr. Knapp's presentation, and that time and a structure for such interaction should be built into future programs.

ADVISORY PANEL ON THE MISSION AND ORGANIZATION OF MEDICAL SCHOOLS

Dr. Cohen suggested that a third advisory panel be appointed to examine the mission and organization of medical schools in these complicated times. He elaborated that the notion would be to obtain the dean-driven view but with a broader perspective from the other Councils and outside experts similar to the other advisory panels. Its purpose, he continued, would be to focus sharply on these issues over an extended, potentially unlimited, period of time, to continue to develop expertise and recommendations that could be brought from time to time to the governance, and to produce monographs, position recommendations and other things that relate to many of the issues that concern the Association. He commented that if the Administrative Board concurred, the staff would immediately begin forming such a group.

Dr. Cohen offered examples of products of such a panel which could be similar to those of the Advisory Panel on Strategic Positioning for Health Care Reform, including in-depth papers that could be produced as a series of monographs on issues such as the expanded responsibility of medical schools with respect to educating other health professionals; the team concept; consortia; faculty rewards and promotion; how to engage the managed care community; the continuum of education--how to wed undergraduate and graduate medical education into a more rational system; recommendations for policy positions by the Association that could form advocacy positions; and the whole range of matters that are impacting on the educational role of academic medicine.

Support was expressed for such an advisory panel, especially if it were to be focused particularly on the medical school because, it was noted, an authoritative articulation was needed of the purpose of the medical school, the rationale behind it and the collating of whatever data backs up various positions. The question was raised whether a continuation of Dr. David Greer's study on dean longevity could be included in the purview of the advisory panel. Dr. Cohen responded that although this specific issue had not been originally envisioned as part of the advisory panel's work, in part because it was seen as a Council of Deans issue, it could be included if it were seen in the context of the impermanence of leadership in the top academic position in medical schools being one of the disfunctional aspects needing study.

Dr. Cohen concurred with another item suggested for the advisory panel's agenda, the need for reconceptualizing the medical school and the academic medical center, inasmuch as all schools were trying to address issues such as what is the core academic faculty member,

how to define it, what are the resource needs, how to reorganize departments, and other large issues which need to be faced. Another member also spoke in support of the reconceptualization study, noting that the University Hospital Consortium has a task force on governance which is looking at the academic medical/health center and suggesting that the AAMC have a role in this study. He referred to the hour-long discussion on tenure and promotion at the new dean orientation session and suggested that the advisory panel look at such issues, perhaps in a broader context.

Dr. Bryan noted that in issues such as tenure and promotion the deans could be advised by their colleagues in the other Councils. It was recommended that since everyone seemed to be wrestling with such issues, the AAMC insure that it have this kind of existential background as a basis for discussion and that the group be broadly representative, including newly appointed deans and members of the public sector.

Dr. Bryan summarized that the consensus was to endorse Dr. Cohen's suggestion for an advisory panel on the mission and organization of medical schools and noted that the deans would be glad to help with the formation of such a panel.

Dr. Cohen raised the issue of whether the advisory panel should look at the cost of medical education issue, the so-called "Third Pot" question and how the AAMC could justify and rationalize this fund to evaluate the sizing. He reported that the consensus at the staff level, with which he concurred, was that this issue should not be included on the advisory panel's agenda but that there should be a subcommittee of the Council of Deans to help oversee the staff work that will be ongoing on a short-term basis. He requested the Administrative Board's advice on the issue. There was general concurrence that this issue should be examined in a more expeditious way than other issues before the advisory panel.

ISSUE BRIEF: ALL-PAYER FUND IN SUPPORT OF THE ACADEMIC MISSION OF MEDICAL SCHOOLS

Mr. Keyes distributed a draft of the Issue Brief (Attachment 1) and observed that it represented an attempt to articulate the advocacy position on the all-payer fund in support of the academic mission of medical schools. He requested that Board members read it so that it could be deliberated within the AAMC before being used in external discussions of the need for such a fund.

A comment was made on the importance of establishing the principle of a separate medical school fund, even though the size of the proposed fund would be dwarfed by the amounts to be allocated to hospitals. Dr. Knapp observed that the size differential was not a problem in the Association's advocacy for the medical school fund. The difficulty for the AAMC, he continued, was educating people to the need for a separate fund.

Agreement in principle with the draft issue brief was expressed, although it was noted that great sensitivity must be used in how the message was to be delivered. An example was given of the cross-subsidization argument being a two-edged sword in that legislators when apprised that schools have used clinical practice dollars to subsidize research or education react by saying that those dollars *should* be removed from the patient care bill and are unsympathetic to the need to replace these monies for education and research.

Other comments were:

- The wording of the draft could create a great liability for schools, particularly when there is no solid data yet on the cost of medical education. Rather than saying clinical income is an increasingly important revenue source, say that a hidden expense of the education of physicians has been borne by academic medical centers through the years by virtue of creating the environment in which education occurs, and that as the margins get squeezed, this capacity cannot be counted on. Eliminate "buzzwords" such as *cross-subsidization* and emphasize that medical schools care about it from the education point of view. The practice plan has to be the jewel in the educational crown, not an income-generating machine. A much different academic environment must be created because schools must teach more in the ambulatory care setting where certain kinds of things are taught and not just assign a student to a doctor who does what he or she has seen somebody else do. In many ways, the environment was passive when it was a hospital-based educational environment. The wording implies that taking care of patients is separate from the research and educational missions, which of course cannot be separated.
- The fact must be communicated that the clinical environment is critical for the medical schools to conduct their missions and that there has been a shift in medical education from the in-patient environment where the costs are relatively inapparent to an environment where the costs are quite a bit more apparent. Schools are dealing with this fact today; it is not an issue coming if there is health care reform. Although it is true that the practice plans subsidize research, the new society goal of research translating into improved health care requires that research be clinically-based in environments which support the quality of care.
- Many deans feel that there is compelling justification for this proposal which is not just to maintain the income stream to medical schools because that was not a valid rationale for people in Congress who need to know the reason for it. First emphasis should be given to the added costs of supporting the parts of the health care reform process that medical schools are supposed to be supporting. In a climate where the income appears to be decreasing, the point of the loss of income cannot be raised to Congress without getting put back on the table the fact that

indigent care is going to be covered which will provide offsetting income to counteract the losses. Until the amount of that offsetting income is determined, this argument is a nullity--they will not listen. The existence of offsetting income as a result of universal coverage should be acknowledged, but the best projections of such income indicate that an income gap will remain and therefore it is logical for the AAMC to advocate for an additional fund.

- Concerning the notion that insuring the uninsured will compensate fully for the loss of subsidies, the fact is that it certainly will not under anybody's model. An issue to be addressed politically is how to get to the point that deans do not anticipate that even under the Health Security Act in its fullest flower that there will be compensatory dollar-for-dollar income for medical schools from the clinical stream. It is a tough thing to grapple with because there are a lot of uncertainties, but no responsible analyst would think there is going to be a dollar-for-dollar exchange.
- Another aspect of this issue is the point made by Dr. Lonnie Fuller of Morehouse at the opening plenary session, that if the indigent are now insured, they are going to be in the marketplace. The competition for that group is going to be the same as it has been for the current marketplace, and medical schools are still disadvantaged in terms of competing for that group because the private payers see them as volume, as part of the marketplace. So medical schools will have the same problem that they have now.
- Still another component is that there will still be women who come in labor to medical school hospitals without any antenatal care, and there will still be gunshots and knife wounds in the inner cities. Academic medical centers will continue to care for these people and there is not going to be enough money to pay for it. That is the issue--disproportionate share. It was noted that Lewin/DHI may have some numbers on indigent care.
- Even though indigent care is going to be provided, that doesn't mean that medical school moneys are there. It may be that hospital moneys are there, but some of the fees for indigent care are not exactly deluxe.
- A dollar amount for the proposed medical school fund is needed, even a placeholder figure pending the results of ongoing studies. It needs to be stated somewhere if deans are going to go see people and hand them a document.
- A formulation of "no less than \$500 million" is currently being used.
- Another approach would be to articulate that in the new competitive marketplace faculty may even be hesitant to teach because it

will affect a number of productivity measures that they will be expected to meet. The teaching emphasis is being shifted to a new setting that requires a way to account for that lost productivity.

- Since this is to be an external document, the point should be made that a medical school is made up of the faculty whose responsibility is to teach students and residents and perform research and so forth. In so doing that, that faculty teaches in the context of taking care of patients. That has generated revenue which helps pay for the salaries of those faculty, helps pay for the research that those faculty do, but also generates income to the school which has been used for other educational and research uses. One of those is that even today it is used in some schools to help offset the cost of education in the primary care and ambulatory care parts of the medical school. Schools with family practice departments have somewhere in the system some subsidy provided for that department compared to a department of surgery or OB/GYN. The case could be made that this is what schools have been doing with these funds and not just because schools needed the money. The funds came because there was a faculty whose responsibility was to do the things that faculty do and then they have generated income.
- The consequences of using the phrase "reluctance on the part of faculty to contribute a portion" could be unfortunate in that a Congressman could say "who's in charge? Aren't you the CEO of this organization?" It would leave deans vulnerable to some discussions that they do not want to get into about the management of their institutions.
- Congress does not use the word "taxation" for a good reason--because it is an aversive term. Deans need to learn from that, i.e., how to package this proposal so that it can be put forward in a way that makes it sound better than what Mr. Ira Magaziner said at the opening plenary session. What he did not say is in many ways far more important than what he said. Academic physicians have this passion for completeness and telling it like it is in terms that they know, but congressional people look at those terms and say "subsidy" and look for red underlines. A premium is placed on the education of primary care physicians but it is difficult to use terms like "taxes," "cross-subsidies," or "you've got to protect the incomes of the medical schools," because Congress does not play that game.
- The proposal as written is appealing to deans, but any endorsement must be tempered by experiences with legislators in which deans are told "most of the people in this room don't know the difference between Medicare and Medicaid." The level of understanding among legislators is very different from the one that deans understand. The proposal must be kept simple and deans must understand the purpose of the document. Although this is understandable to a dean, phrases such as "reluctance on the

part of faculty members to contribute a portion of their compensation" should not be put in any legislator's hand. But the idea should be included that it will be more difficult to teach ambulatory medicine and it will cost more and that if that cost is not reimbursed, that is going to be a problem, and that gets into an issue they can understand.

- The crafting of this obviously has to be maximally sensitive to what the audience is. It is a terrific start and the Association has come a long way in trying to get some thoughts on the table. It is a difficult position to articulate and obviously one wants to make it as politically comfortable as possible. Some say that the focus should be on "we're going to do ambulatory care and we're going to do primary care, and that's the rationale for the money." Others may say that there is another argument that is difficult to sell which is that schools have been cross-subsidizing (or whatever term is used) and that to replace lost medical school income, it is a formidable task to find anybody to be terribly sympathetic about that. Many people in academic medicine are there and give up a certain larger percentage of their income being there because they want to be in academic medicine. That would be a very difficult point to get across, and it is complicated by the fact that whereas some internists may as a result be seeing a cut which people might feel is something to be concerned about, people might still feel that perhaps some neurosurgeons are not exactly experiencing that much of a cut. The point is not to give up too quickly the challenge of trying to find some way of articulating this need to replace lost income because if you do not, then the money is going to be increasingly pegged to how many primary care people and how much ambulatory care you are providing. The task should not be trivialized. It is difficult to get this explained in a way that is both politically attractive and also accurate, but it should not be abandoned too quickly.
- In some marketplaces academic internist/pediatricians and psychiatrists are making more than the average practice in internists/pediatricians and psychiatrists. It was emphasized that this was a point that had to be dealt with very carefully and that the issue of "preserving delta" is mainly in the surgical specialties.
- It is important that the interpretation does not become that the medical schools are trying to sustain the current level of physician income. They are trying to sustain the current level of medical school funds, recognizing that physician income will probably fall. The choice of words is important; for example, deans might think of "clinical income" as something that comes to the dean but in the minds of most readers, clinical income is what goes to a doctor to pay his salary. How this is crafted has to create the imagery of what really is okay--that clinical income in the sense of doctors' salaries can fall but the

clinically derived revenue for the medical school is a fixed expense and cannot fall.

- Should the assertion be made that tuition does not and cannot pay for medical education because the suggestion will be made to "just turn it over to tuition"? Traditionally, it has not and it is not likely that it can. How does one get that point across, which is never seen in the documents?

It was noted that the point was included in the sentence at the end of the background paragraph. Comment was made that the chief health staff person for a congressman prominent in health issues had said after a presentation by deans, "I don't understand all of this. Why is it that you can't just charge enough tuition and be done with it?"

Although the answer is obvious to academic medical people, the point is just how limited the insight is on Capitol Hill.

- The \$60 million figure probably underestimates the total for school-based scholarships at all schools across the country for facilitating indigent students at medical schools because three of the eleven schools represented at this meeting provide from their operating budgets amounts between \$3-4+ million on an annual basis for such scholarships. Although state schools probably do not have that much money, other endowed schools probably provide aid at a similar level, so the total scholarship figure should be greater than \$60 million for all schools.

There was some discussion of this point and it was noted that some of scholarships at some schools are merit and not need-based scholarships, but they are reported on these schools' Scholarship and Loan Fund Reports. It was agreed that the figure would be rechecked to be sure that it is defensible.

Dr. Knapp summarized the main points:

- Eliminate the first bullet under consequences or at least state it differently.
- The fundamental problem statement which would appear under Issue is to describe the newer expanded responsibilities of the college of medicine in a new environment for training in support of health care reform.
- The lost money issue can be made the residual on the back end if it appears that the point should be included.
- On the point of including an explicit "plug-number" as an estimated amount for the fund, Dr. Knapp expressed that he thought such a number could be expressed verbally rather than putting it in the brochure. He recommended that deans visiting legislators could say, "we want a billion or a billion and a

half, but we'll start with \$500 million in 1996. That's the answer."

- He advised that financial projections on the compensation issue for indigent care should not be included in this document.

Discussion continued to insure general understanding, and the following points were reiterated:

- The bullets on the first page still seem to emphasize economics. For example, rather than helping to pay for clinical faculty members' time, schools are paying for the cost of education and research. References to recruiting new faculty could also be deleted as well as the phrase, "economic pressure on physician faculty members." The point is that this formulation is the wrong way to say that, that the board members want to avoid this type of phrasing and perhaps even take faculty out of it. The consensus was that rather than putting the focus on trying to relieve the financial distress of the doctor, what the schools want is to talk about the programs they are doing.

It was noted that of the usual and customary charges billed by a faculty member there is implicit a built-in support for the school's educational mission. It is not going into the hip pocket of the doctors who are doing the billing.

Mr. Keyes observed that one way to get to a "plug-number" that is supportable in the longer run is for the deans to return the survey concerning their estimate of the impact of health care reform. As of April 15, he noted, only 21 medical schools had returned the survey. He reiterated a point made at the plenary session that the survey should be completed by the dean rather than the school's financial officer. It was noted that a reminder would be given to attendees at the business session later in the meeting.

1994 ANNUAL MEETING

Dr. Hallock reported on behalf of Drs. Daugherty and Fialkow that there had been a telephone conference among the committee members, with the result being a suggestion that the Fall Meeting could be used as an opportunity for a town meeting with Dr. Cohen. The rationale would be that Dr. Cohen would make a report to the deans after having been *in situ* for about six months and then give the deans an opportunity to talk to Dr. Cohen.

There was some discussion over whether this session should be an open session, and the consensus was to have a closed session which would not be listed in the general program.

Dr. Daugherty added that the traditional session on rural health could be used as a joint session with the COTH, perhaps on consortia or other immediate issues, and try to build on what had been accomplished at the last Administrative Board meeting. It was recommend-

ed, to general concurrence, that a way be found to include the CAS in the discussion.

The topic was suggested that in some cities with several medical schools (for example, Chicago) schools are asked to come together and do things that are less costly than having each school doing everything. The question was posed as to whether the advisory panel would look at things like this that have been successfully done by medical schools so some generic ideas could be generated on how to go about sharing departments and what could be the possible barriers to accomplishing such innovations.

COUNCIL OF DEANS MISSION STATEMENT

Dr. Bryan announced that a draft of the mission statement would be distributed at the business session later in the Spring Meeting.

ADJOURNMENT

The meeting adjourned at 1:35

DRAFT

Issue Brief

ALL-PAYER FUND IN SUPPORT OF THE ACADEMIC MISSION OF MEDICAL SCHOOLS April 1994

Issue:

In the 1990s, competitive pressures--a result of market forces and state reforms--are altering the health care delivery system. Medical school financing, currently heavily dependent on clinical practice revenues generated by faculty physicians, may be eroded by a market highly sensitive to price. Funds that medical schools derive, which are generated by their faculties from providing clinical services, are used to support the educational and research missions of academic institutions. Changes occurring in the delivery of health care threaten this clinical service revenue stream and the academic mission for which it pays.

In local markets dominated by competitive health care organizations, the traditional functions of medical schools and teaching hospitals will come under increasing and diverse pressure. Integrated private health care systems will seek to control their costs by negotiating discounts that eliminate the extra costs of teaching and research...(Blumenthal and Meyer, NEJM Dec. 9, 1993).

Therefore, a separate stream of revenue to support the academic mission of medical schools in an era of health care reform should be established beginning January 1, 1996. These funds would complement those already identified in the Health Security Act (HSA) to support the direct costs of training residents, and the special costs of teaching hospitals.

Background:

Clinical income derived from providing patient care services, has become an increasingly important revenue source for financing medical school activities. At the same time, changes in the health care delivery system highlight the need to undertake new educational initiatives. Medical schools are being asked to expand ambulatory educational experiences and to provide an environment to support the training of generalist physicians. In FY 1981, clinical income from medical service plans accounted for 15.7 percent of medical school revenues. In comparison, in FY 1992 this revenue stream accounted for 32.4 percent. Although these funds are used to compensate clinical faculty for providing patient services, a significant component is redirected to cover those costs of medical school academic programs that are not supportable by tuition and fees and state appropriations. Generally, these funds are used by medical schools in the following ways:

- Helping to pay for clinical faculty members' time spent teaching and conducting research;
- Assisting in the support of basic science faculty and departments, and other faculty and departments essential to the academic mission that are not self-supporting;
- Recruiting new faculty;
- Underwriting curricular innovations;
- Providing seed money and start-up funds for promising new initiatives not yet ready for formal grant proposals;

- Supporting the academic infrastructure in those cases where the costs are not fully reimbursed by outside sponsors; and
- Supporting school-based scholarships at a level of nearly \$60 million per year over the past ten years.

If clinical income is significantly reduced, medical schools will be faced with some of the following consequences:

- Reluctance on the part of faculty members to contribute a portion of their compensation to support the medical school;
- Economic pressure on physician faculty members to focus their energies on revenue generating clinical activities at the expense of teaching and other academic responsibilities.
- Increasing pressure to limit the teaching commitments of faculty;
- Requests by voluntary faculty, who play an important role in the education of medical students, for compensation for teaching because of loss of income from their private practices (in a fee-for-service setting) and for their time (in HMO setting); and
- Loss of the academic milieu as it becomes more responsive to the incentives of the marketplace.

These consequences will occur while medical schools are working to shift their educational emphasis from specialty care to generalist care; from hospital settings to ambulatory settings. Thus, there will be a potential search for funds to:

- Develop ambulatory teaching capability, a more expensive teaching mode than hospital-based teaching because of the reduced physician productivity;
- Recruit more generalist physicians to educate medical students and serve as role models and career counselors;
- Utilize HMOs, which require compensation as teaching sites; and
- Increase compensation to recruit and retain generalists.

Solution:

The HSA and the Cooper/Breaux (HR 3222/S 1579) bill expand revenue streams through a all-payer approach to support the costs of graduate medical education. The HSA includes a separate fund for the specialized services and treatments provided by teaching hospitals. However, there is no proposal that explicitly acknowledges and attempts to ameliorate the impact of the impending changes on medical schools. Thus, we recommend the creation of a fund to which all public and private payers will be required to contribute beginning January 1, 1996. This fund will form the basis of a separate revenue stream dedicated to the preservation of the academic mission of medical schools in an era of health care reform. An independent analytic body should complete study by July 1, 1995 on the appropriate size and availability of the fund and the payment methodology for distributing the funds. The results of the study could be incorporated into funding for January 1, 1996 or whenever an all-payer system is established.

STUDY GROUP ON THE DEVELOPMENT OF A MISSION STATEMENT
FOR THE COUNCIL OF DEANS

Members of the Study Group:

George G. Bryan, M.D., Chair
Giles G. Bole, M.D.
Gerard N. Burrow, M.D.
Nilda Candelario, M.D.

William A. Peck, M.D.
Stephen J. Ryan, M.D.
Robert C. Talley, M.D.
I. Dodd Wilson, M.D.

The draft mission statement on page 2 was distributed for comment at the business meeting on April 20, 1994, in Palm Beach, Florida.

The draft mission statement on page 3 is a suggested revision prepared by staff on the basis of comments received.

RECOMMENDATION: That the Administrative Board consider the drafts and approve a mission statement that reflects its best judgment.

DRAFT

April 15, 1995

MISSION STATEMENT OF THE COUNCIL OF DEANS

The purpose of the Council of Deans, as a major arm of the Association of American Medical Colleges, is to impact the overall mission of the AAMC by assisting in the promulgation of its policies, and participating in all the affairs of the AAMC. The Council of Deans, in collaboration with the Council of Teaching hospitals and Council of Academic Societies, will direct programs and activities of the AAMC by setting and initiating AAMC policies that are directly relevant to their institutions. In pursuing its purpose, the Council of Deans will work to strengthen the ability of deans to lead individual schools in serving the public, through their missions of excellence in medical education, research and patient care. The Council will enable deans to support their respective constituencies of students, graduate physicians-in-training, physicians and faculty. The Council of Deans will work with its members to provide: mentoring for and professional development of deans; help in fulfilling individual school missions; a network for development of decanal consensus by involving the broad perspectives of its members; a national forum for all medical schools; and a forum for medical school deans' advocacy within and through the AAMC.

The Council of Deans consists of the dean or designated chief academic officer of each medical school member of the AAMC. The Council's principal mission is to be a forum for deans to consider issues affecting medical schools, to develop programs for the benefit of its members, and to propose policies to guide the AAMC in its service and advocacy functions. These functions are overseen or performed by the Council's Administrative Board and through its representatives on the AAMC Executive Council (the AAMC board of directors). The Executive Council is the principal means by which the COD collaborates with other participants in AAMC governance: the Council of Teaching Hospitals, the Council of Academic Societies, and the Organizations of Student and of Resident Representatives. The COD seeks to serve the public welfare by strengthening the deans' ability to lead individual schools toward excellence in medical education, research and patient care.

Thus, the COD provides:

- mentoring for and professional development of deans;
- a venue for deans to address the concerns of their constituencies: medical students; graduate students in the life sciences; physicians-in-training; physicians and scientists on medical school faculties;
- assistance to deans in fulfilling individual school missions;
- a means for deans to develop consensus among their broad and varied perspectives; and
- a conduit for deans to advocate their views within and through the AAMC.

STUDY GROUP ON THE ROLE OF MEDICAL SCHOOLS
IN GRADUATE MEDICAL EDUCATION

Members of the Study Group:

Richard A. Cooper, M.D., Chair	Herbert Pardes, M.D.
Thomas J. Cinque, M.D.	Robert L. Summitt, M.D.
James A. Hallock, M.D.	Daniel H. Winship, M.D.
Allen R. Myers, M.D.	

[The following is a reproduction of the slides used in the report by Dr. Richard Cooper at the business meeting on April 20, 1994, in Palm Beach, Florida.]

ISSUES

- (1) Underlying Physician Workforce Issues
 - Current needs
 - Projected deficiencies, surpluses
 - Role of GME
 - Other Strategies
- (2) GME Program Issues
 - Independent programs
 - Medical school involvement
 - Consortia
- (3) GME Governance Issues
 - National GME board
 - Regulatory processes
- (4) GME Financing Issues
 - Origin of Funds (All Payor Pool)
 - Formulas for Distributing of Funds

AAMC GENERALIST POSITION

"The Association of American Medical Colleges advocates as an overall national goal that a majority of graduating medical students be committed to generalist careers and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time."

THE "50% SOLUTION"

Premise

"No more than 30% of this country's practitioners are generalists."

"In other industrialized countries, generalists constitute 50-70% of practitioners."

RECOMMENDATION: Establish a continuous strategic planning process to formulate national policy governing physician workforce needs (as recommended by the AAMC Generalist Task Force).

50% REGULATION

"Be careful. The opportunities are legend for exercising the law of unintended consequences." (Cohen)

"Federal and State legislators are telling medical educators to produce a 50-50 balance of generalists and specialists - or else." (The Internist)

Note: State legislatures considered 70 "Medical Education Reform" bills in 1993.

RECOMMENDATION: Develop strategies to avoid legislative regulation of the education process.

DISTRIBUTION

"The problem (in providing care for the underserved) is more one of distribution than it is of aggregate supply." (Kellogg Foundation)

Expand class size,
Train more generalists,
Three strikes and you're out!

RECOMMENDATION: Develop strategies for dealing with the problems of distribution independent of overall changes in the physician workforce.

COUNCIL OF DEANS RESOLUTION ON GME NOVEMBER 8, 1993

The Council of Deans affirms:

- (A) Education is the core mission of medical schools.
- (B) Medical schools necessarily have a central role in assuring the quality and composition of tomorrow's physician workforce.
- (C) Consortia, as described in the AAMC's July 1993 position paper on Graduate Medical Education, represent an effect means of accomplishing the tasks and processes required for GME programs of the future.

Therefore, the Council of Deans proposes the following:

- (1) Consortia should be the instruments for local control, collaborative decision-making and resource allocation for GME.

- (2) One or more medical schools must be participants in each local consortium.
- (3) Medical schools must be responsible and accountable for the educational process and product of the consortia.
- (4) Medical schools should serve as the fiscal agents for GME consortia.
- (5) The COD will work with the COTH and others within the AAMC to establish these principles and goals as official policy of the AAMC.

AAMC POLICY - FEBRUARY 24, 1994

AAMC: The AAMC affirms that ideally:

COD: The COD proposes the following:

I. AAMC: Consortia should be the focal point for collaborative decision-making and resource allocation and coordination for GME based on needs assessment.

COD: Consortia should be the instruments for local control, collaborative decision-making and resource allocation for GME.

II. AAMC: Consortia should include one or more medical schools as participants.

COD: One or more medical schools must be participants in each local consortium.

III. AAMC: Medical schools should provide leadership, in cooperation with their teaching partners, for the GME educational process and product.

COD: Medical schools must be responsible and accountable for the educational process and product of the consortia.

IV. AAMC: Payments for GME should be made to the organization or entity that incurs these costs or to a designated agent such as a consortia.

COD: Medical schools should serve as the fiscal agents for GME consortia.

GME RECOMMENDATIONS

- I. CONSORTIA
 - Develop information on existing consortia
 - Discuss consortia at COD session of AAMC national meeting in November and plan "consortium workshops."
Note: Consortia will be discussed at AMA Medical Schools Section in June.

- II. EXPLORE OTHER GME ISSUES:
 - GME Governance/Regulation
 - GME Financing

- III. Continue dialogue with COTH and CAS regarding the role of medical schools in GME.

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COUNCIL OF DEANS PROGRAM AT 1994 ANNUAL MEETING

Members of the *ad hoc* planning committee for the COD program:

James A. Hallock, M.D., Chair
Robert M. Daugherty, Jr., M.D., Ph.D.
Philip J. Fialkow, M.D.

TENTATIVE PROGRAM OUTLINE

Saturday, October 29

6:30-7:30 pm New Deans Reception

Sunday, October 30

9-11:30 am Community-Based Deans Breakfast Meeting

Noon-1 pm Private, Freestanding Deans Luncheon

1-2:30 pm COD Town Meeting with Jordan J. Cohen, M.D. (closed session)

Monday, October 31

7-8:30 am Issue or Regional Group Breakfasts (4 rooms reserved)

11:30-1 pm Administrative Board Luncheon

1-4 pm COD Annual Business Meeting

4:30-5:45 pm Private Exhibition for COD of RIME Exhibits

7-10 pm 1994 Fall Dinner (away from hotel)

Tuesday, November 1

12-1:30 pm 1995 Spring Meeting Planning Committee Luncheon

1:30-3:30 COD/COTH Joint Plenary Session on Consortia

The CAS will advise whether they will participate in this session.

Current plans envision 2-3 short presentations of working models, with the candidates for working model being SUNY-Buffalo, Michigan State, and Tennessee. Following the presentations, substantial time will be reserved for discussion.

Wednesday, November 2

9-11 am

Rural Health Session

To be determined: Advice from the Administrative Board is requested on whether to hold this session.

DEANS' SURVEY ON THE FINANCIAL IMPACT
OF HEALTH CARE REFORM ON MEDICAL SCHOOLS

ISSUE: AAMC advocacy for an all-payer fund in support of the academic mission of medical schools requires that we develop credible data in support of that fund's rationale. This includes developing estimates of the extent to which clinical revenues, now threatened by managed care and price-competition, are currently directed to the support of teaching and research.

BACKGROUND: On April 1, 1994, the AAMC mailed a survey to all medical school deans requesting information in support of the rationale for a "medical school fund." It directed questions to:

- 1) the extent to which clinical revenues support medical student education and research;
- 2) the deans' projections of the impact of price competition and health care reform on clinical revenues in the future;
- 3) planned changes in educational programs that would increase annual educational costs, and estimates of those costs; and
- 4) deans' views on seeking a federal subsidy for medical school programs in health care reform legislation.

A total of 54 medical school deans responded to the survey. A summary report of the survey results is attached.

A preliminary summary of these results (based on a smaller number of respondents) was presented to the AAMC Advisory Panel on Biomedical Research and the Advisory Panel on Strategic Positioning for Health Care Reform. Those discussions led to three conclusions: 1) while getting certain estimates was difficult, the effort was worthwhile; 2) the limited number of deans that participated was disappointing; and 3) the AAMC staff, in consultation with deans, should devise a new survey form with clearer definitions to produce more precise estimates.

AAMC staff are developing this revised survey form to obtain refined estimates on the amount of clinical revenues that currently support teaching and research. The most recent version of that form will be provided to the Board as a handout at the meeting.

DISCUSSION: The Board is requested to comment on the revised form and on how to obtain a higher response rate. It also may suggest ideas for addressing some of the other finance questions, for example, how to estimate the increased costs of ambulatory education, that will serve as the basis of the agenda of the new AAMC Task Force on Medical School Financing.

THE FINANCIAL IMPACT OF HEALTH CARE REFORM ON MEDICAL SCHOOLS:
SUMMARY REPORT OF A SURVEY OF MEDICAL SCHOOL DEANS

HIGHLIGHTS

- A total of 54 medical school deans (43 percent) responded to the survey.
- From data provided by 43 schools, we estimate the national aggregate amount (126 schools) of clinical revenues used in support of medical student education and research at \$1.5 billion. This figure represents approximately 18 percent of medical school revenues from faculty practice plans, reported by the 126 member schools for 1992-1993. For several reasons, this figure is likely to be a conservative estimate.
- Approximately 44 percent of these revenues, or \$663 million, is directed to the support of medical student education. Approximately 56 percent, or \$861 million, is directed to support of research.
- Medical school deans found it difficult to project how clinical revenues would be affected by price competition and health care reform in the future. Of those who ventured an estimate for the near term (1996), 70 percent predicted that their revenues would flatten or decrease. Deans were even more pessimistic about the longer term (2000).
- Virtually all deans expect to be making changes in educational programs that will increase annual costs, but few (27) were able to estimate these increased costs. Estimates that were given tended to vary greatly, even when normalized to a per-student amount. Extrapolating from these estimates yields a national aggregate amount (126 schools) of approximately \$277 million in increased annual educational costs.
- There is virtually universal support among the deans for the decision to seek a federal subsidy for medical school programs in health care reform legislation.

SUMMARY

We mailed a survey to all 126 U.S. medical school deans requesting information on the following:

- 1) the amount of clinical revenues used in support of medical student education and research and their allocation for those purposes;
- 2) the deans' projections of the impact of price competition and health care reform on clinical revenues in the future;
- 3) planned changes in educational programs that would increase annual educational costs, and estimates of those increased costs; and
- 4) the deans' views regarding the decision to seek a federal subsidy for medical school programs in health care reform legislation.

A total of 54 medical schools returned questionnaires. Of these, 43 schools were able to provide information on the first question. The 43-school sample is similar to the population in the balance of public vs. private schools (58% vs. 42% for population; 60% vs. 40% for sample). The 43-school sample is biased toward larger schools with a greater share of federal research and clinical practice revenues:

	<u>Sample</u>	<u>All Schools</u>	<u>% of All Schools</u>
Number of schools	43	126	34
Total medical school revenues - median:	\$205 million	\$169 million	38
Federal research revenues - median	\$33.3 million	\$21.1 million	37
Medical practice plan income - median	\$83.9 million	\$65.7 million	43

Estimates of national aggregate amounts of clinical revenues used in support of academic programs, shown below, are adjusted to take into account the sample's disproportionate share of medical practice plan income.

CLINICAL REVENUES IN SUPPORT OF ACADEMIC PROGRAMS

Estimates of the amount of clinical revenues used in support of medical student education and research ranged from \$750 thousand to \$50 million per school. The mean was \$15.4 million. The total of these revenues among the 43 schools was \$661 million. After adjusting for the disproportionate share of medical practice plan revenues among the sample schools, we estimate a national aggregate amount (126 schools) at \$1.5 billion.

This estimate is likely to be conservative. While nearly all schools included in their estimates revenues from a "dean's tax" and a "departmental tax," fewer were able to assess the proportion of salary support provided by clinical faculty from their practice earnings that indirectly pay for teaching and research activities. Also, no respondent appeared to venture an estimate of the support of non-paid, volunteer faculty that represents a subsidy to the academic program. The latter two are important ways that clinical practice supports academic programs.

USE OF CLINICAL REVENUES

The percentage of these revenues applied to medical student education had a median of 46% and a range that extended from 9.8% to 100%. The percentage applied to research had a median of 54% and a range of 0% to 90.8%. By applying these percentages to the revenue figures provided by schools, we derive the following estimates:

Per-School Estimates

<u>Clinical revenues</u> <u>in support of</u>	<u>Mean</u>	<u>Range</u>
-medical student education	\$6.7 million	\$392 thousand-\$23.4 mill.
-research	\$8.7 million	\$0 -- \$42.5 million

National aggregate amounts can be calculated in the same way as above:

<u>Clinical revenues</u> <u>in support of</u>	<u>Sample Estimate</u>	<u>National Aggregate</u>
-medical student education	\$288 million	\$663 million
-research	\$374 million	\$861 million

PROJECTED CHANGES IN CLINICAL REVENUES

A total of 37 schools ventured estimates on the changes in clinical revenues expected in 1996; only 28 schools ventured estimates for the year 2000. Because of the "soft" nature of the data and limited number of schools responding, we analyzed these estimates only in terms of the direction of change, as shown below. Schools hold mixed views on the near-term impact of price competition and health care reform on clinical revenues. Still, after several decades of expanding clinical revenues, the number of schools that now project a flattening if not decline in the near future is worthy of note. Schools were generally even more pessimistic about the longer term.

<u>Expected changes in clinical revenues</u>	<u>Number of Schools</u>	
	<u>1996</u>	<u>2000</u>
Will increase	11	6
No change	14	5
Will decrease	<u>12</u>	<u>17</u>
Total	37	28

INCREASED ANNUAL COSTS OF EDUCATIONAL PROGRAMS

Nearly all schools reported that they planned changes in educational programs that would add to their educational costs, but only 27 schools ventured estimates of these costs.

Expected Increases in Annual Educational Costs

	<u>Median</u>	<u>Mean</u>	<u>Range</u>
Total School Costs	\$1.5m	\$2.2m	\$230k -- \$5.5m
Per-student cost	\$3750	\$4115	\$375 -- \$13,513

Extrapolating the mean school cost (\$2.2 million) to a national aggregate (126 schools) yields an estimate of \$277 million. However, the large variability among schools limit the utility of these data for policy purposes.

SUPPORT FOR AAMC POSITION TO SEEK A FEDERAL SUBSIDY

In narrative comments, respondents expressed strong support of the AAMC's decision to seek a subsidy for medical school academic programs in health care reform legislative proposals.

SITE AND DATES FOR 1997 SPRING MEETING

At the June 16-17, 1993, Administrative Board meeting, members requested that site selection for future spring meetings be determined three years in advance rather than the previous planning schedule of two years. This was recommended to insure that deans would receive as much notice as possible of future Council meetings.

Ms. Marcie Foster, Director, Section for Professional Education Programs, will present material on possible 1997 sites and dates for consideration at the June 15-16, 1994, Administrative Board meeting.

MINORITY HEALTH IMPROVEMENT ACT

Current Status: Under suspension of the rules, the House May 23 approved H.R. 3869, the Minority Health Improvement Act of 1994, which would revise and extend a series of programs designed to improve the health of minority populations.

H.R. 3869, introduced by Rep. Henry Waxman (D-Calif.), would combine the Exceptional Financial Need (EFN) scholarship, the Financial Aid for Disadvantaged Health Professions Students (FADHPS) scholarship, and the Scholarships for Disadvantaged Students (SDS) programs into one grant program. Students from disadvantaged backgrounds pursuing careers in generalist medicine (family medicine, general internal medicine, general pediatrics, and general obstetrics-gynecology), general dentistry, nursing, and mental health would be eligible for the new scholarship.

Under the terms of the new program, a recipient would receive a scholarship in the amount of tuition and other educational expenses, as well as a monthly stipend, in exchange for a commitment to deliver primary-health-care services in a federally-designated health professional shortage area. For each year of scholarship support, the recipient would be required to serve for a year in such practice.

H.R. 3869 stipulates that the new program would be administered by the Bureau of Primary Health Care, which includes the National Health Service Corps, within the U.S. Department of Health and Human Services. The bill also would require the bureau to set aside 20 percent of appropriated funds for nursing students and 15 percent of appropriated funds for graduate students in mental health practice.

Among the bill's other provisions are several changes to the Health Careers Opportunity Program (HCOP). H.R. 3869 would expand the focus of HCOP to include the identification of promising minority students at elementary schools as well as secondary schools. The bill would stress the use of grant funds for recruitment efforts and eliminate the use of HCOP funds for retention activities. In addition, federal support for HCOP projects would be limited to six years, and grant recipients would be required to contribute non-federal matching funds beginning at 20 percent of HCOP costs in the second year of the grant cycle.

The Senate March 25 approved its version of the minority-health bill, S. 1569. The bill does not combine the EFN, FADHPS, and SDS programs, but maintains the primary-care service requirements attached to EFN and FADHPS in 1992.

The House conferees are Reps. Dingell (D-Mich.), Waxman (D-Calif.), Richardson (D-N.M.), Towns (D-N.Y.), Washington (D-Tex.), Moorhead (R-Calif.), Bliley (R-Va.), and Bilirakis (R-Fla.). The Senate conferees have not been named as of yet.

AAMC Actions to Date: The AAMC, per Executive Council direction, has continued to oppose the attachment of service obligations to need-based student financial assistance. During the 1993 annual meeting, AAMC staff coordinated visits with congressional staff by members of the Organization of Student Representatives and Group on Student Affairs to discuss our concerns regarding the service requirements. In addition, members of the GSA-Minority Affairs Section sent letters opposing the service requirements to members of Congress earlier this year.

After the House version of the minority-health bill was introduced in February, AAMC staff discussed our opposition to Mr. Waxman's approach with his staff. Rebuffed at that level, the governmental-relations staff collaborated with staff to Rep. Ed Towns (D-N.Y.), as well as Energy and Commerce Committee minority staff, to seek modifications to H.R. 3869. Our efforts were unsuccessful at the subcommittee and committee markups.

Recently, AAMC staff has been working with members of the Congressional Black Caucus (CBC), particularly Reps. Towns, Craig Washington (D-Tex.), and Louis Stokes (D-Ohio). The CBC has a number of concerns regarding the Waxman bill and shares our position against service obligations for disadvantaged students. Rep. Stokes, who earlier this year introduced legislation that would eliminate the service requirements for EFN and FADHPS for disadvantaged students, has informed AAMC staff that Rep. Waxman has agreed to work to meet the concerns of the CBC during conference negotiations.

Future Steps: As soon as the Senate has named its conferees, the AAMC will issue an action memo urging the House and Senate conferees to support inserting the Stokes provisions on scholarships in the final conference agreement. Although the Stokes provisions are not part of either the Senate or House bill, and therefore technically not "conference-able" items, the service requirements originally attached to EFN and FADHPS in 1992 were included during conference and were not part of either chamber's bill.

The AAMC also plans to continue working with Rep. Stokes and his CBC colleagues, as well as concerned members of the community, such as the National Medical Association, the Association of Minority Health Professions Schools, and the American Medical Association, to achieve the objectives set forth by the Executive Council.

[Following this summary are two items: (1) a two-page position paper on the minority-health bill used during November's annual meeting and updated since then for distribution to congressional staff, and (2) a letter sent recently to Rep. Dingell, chairman of the House Energy and Commerce Committee, outlining the AAMC's position on the bill.]



December 17, 1993

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

2450 N STREET, NW
WASHINGTON, DC 20037-1126
TELEPHONE (202) 828-0400

The Disadvantaged Minority Health Improvement Act of 1993

In reauthorizing the Disadvantaged Minority Health Improvement Act, the AAMC urges Congress to

- restore EFN and FADHPS to their previous terms as solely need-based financial aid programs, and
- avoid adding a service requirement to the need-based SDS and LDS programs.

Background: The Disadvantaged Minority Health Improvement Act of 1993 will extend a number of programs created to improve the delivery of quality health care to underserved minority populations and assist disadvantaged and minority students in their pursuit of a career in the health professions. Among the several programs to be reauthorized are four financial aid programs originally designed for disadvantaged and needy students: Exceptional Financial Need (EFN) scholarships, Financial Aid for Disadvantaged Health Professions Students (FADHPS) scholarships, Scholarships for Disadvantaged Students (SDS), and Loans for Disadvantaged Students (LDS).

The Health Professions Education Extension Amendments of 1992, P.L. 102-408, added a primary-care service requirement to the EFN, FADHPS, and the Health Professions Student Loan program (now the Primary Care Loan program). The AAMC objected to these changes, arguing that disadvantaged students should not be required to enter into service obligations to qualify for need-based financial assistance.

The Senate Labor and Human Resources Committee Oct. 20 approved a bill, S. 1569, that would not extend a service requirement to SDS or LDS, but would not restore EFN and FADHPS to their previous terms and conditions. The AAMC continues to urge the House Energy and Commerce Committee to approve legislation that restores and maintains EFN, FADHPS, SDS, and LDS as solely need-based financial assistance programs.

Rationale: While the AAMC agrees with the importance of training a greater number of generalist health-care providers, our member institutions are striving to increase the number of students from under-represented minority groups and disadvantaged backgrounds, regardless of the student's choice of discipline or specialty. The AAMC strongly believes that disadvantaged medical students should not be forced into premature career decisions in order to access low- or no-cost aid for financing their education.

EFN, FADHPS, SDS, and LDS have traditionally been integral components of medical schools' efforts to offer financial aid packages that reduce the costs of education for disadvantaged students. As schools embark upon efforts to recruit and educate more minority and disadvantaged students, EFN and FADHPS could, if returned to their pre-1992 rules, greatly assist their efforts.

FADHPS, in particular, is a set-aside of the Health Careers Opportunity Program (HCOP) and was designed to support HCOP's goal of preparing talented minority students for careers as health professionals. The early-identification and continuum concepts of HCOP are impeded by attaching a service requirement to FADHPS.

The U.S. Department of Health and Human Services awarded over \$20.3 million in EFN, FADHPS, SDS, and LDS funds to medical schools for academic year 1993-94 awards to students. Without access to these programs, disadvantaged health professions students who serve in areas other than generalist medicine will be faced with increased debt loads and more difficult repayment schedules. EFN and FADHPS, which are currently unavailable to these students, represent over \$10.2 million, or slightly more than 50 percent, of the total available to disadvantaged medical students through all four programs. An inability to access these funds creates additional barriers for students from disadvantaged backgrounds who are interested in the health professions but unsure of their eventual practice choice.

[For more information contact Stephen Northrup, AAMC Office of Governmental Relations, at 202-828-0526.]

Jordan J. Cohen, M.D.
President

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

2450 N STREET, NW
WASHINGTON, DC 20037-1126
TELEPHONE: (202) 828-0460

May 23, 1994

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman:

As president of the Association of American Medical Colleges (AAMC), I write to express AAMC's particular opposition to the provisions regarding scholarships for disadvantaged health-professions students in section 301 of H.R. 3869, the Minority Health Improvement Act, as approved by your committee.

The AAMC shares many of the concerns that have been transmitted to you recently by Congressman Louis Stokes and his fellow Congressional Black Caucus colleagues about the contents of H.R. 3869. At this time, I wish to highlight and expand upon one of these items. H.R. 3869 would combine three scholarship programs (EFN, FADHPS, and SDS) into one new scholarship available only to students from disadvantaged backgrounds who agree to practice primary health care in a medically underserved area after completing their training. These provisions expand upon the addition of a primary-care service requirement to the EFN and FADHPS programs, strongly opposed by AAMC, during conference negotiations on the Health Professions Education Extension Amendments of 1992, P.L. 102-408.

The AAMC and its member institutions, since the 1992 amendments, have continuously expressed to members of Congress our position that disadvantaged students should not be required to enter into service obligations to qualify for need-based student financial assistance. Although the AAMC recognizes academic medicine must strive to produce more generalist physicians, we must also fulfill our mission to educate more physicians from underrepresented and disadvantaged minority groups, regardless of the specialty the physician chooses to practice. Most minority populations in this country are underrepresented in all of the medical specialties, as well as in research and teaching.

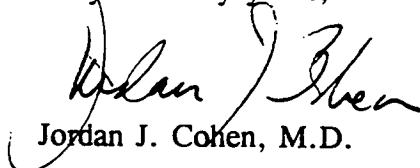
As you know, Congressman Stokes introduced last November a version of the minority-health bill co-sponsored by eleven members of the Congressional Black

Page Two -- The Honorable John D. Dingell
May 23, 1994

Caucus. The Stokes bill, H.R. 3699, would repeal the service obligations for disadvantaged and underrepresented minority students that were attached during the 1992 amendments to the EFN, FADHPS, and Health Professions Student Loan programs. The AAMC supports expanding the Stokes language to repeal fully these service obligations for all students, whether disadvantaged, minority, plurality, or majority. Redressing the imbalance between generalists and specialists is a collective effort that academic medicine and the nation must jointly address. No one group or population should be asked to bear the balance of this responsibility alone.

I understand H.R. 3869 will be approved shortly by the House under suspension of the rules. During conference, I urge you to reconsider the positions approved by your committee and allow modifications to the bill that would enable schools to meet the financial needs of disadvantaged medical students without asking these students to make premature career choices. Although the education of more generalist physicians is a goal we both share, I believe that we can achieve this objective without requiring disadvantaged and underrepresented minority students to commit to a specific practice before they are ready to do so. If you would like to discuss this further, please have a member of your staff contact Stephen Northrup at 202-828-0526.

Very sincerely yours,



Jordan J. Cohen, M.D.

cc: The Honorable Thomas J. Bliley, Jr.
The Honorable Kweisi Mfume
The Honorable Carlos J. Moorhead
The Honorable Louis Stokes
The Honorable Henry A. Waxman

COUNCIL OF DEANS 1994 SPRING MEETING
REPORTS ON SMALL GROUP DISCUSSION SESSIONS

On the following pages are summaries of the reports of the small group discussion sessions held at the 1994 COD Spring Meeting.

The groups made no recommendations for follow-up action by either the Council of Deans or its Administrative Board.

Recruitment, Training and Retention of Clinician Scientists

Facilitator: Harold J. Fallon, M.D.

Reporter: Michael M. E. Johns, M.D.

The original title of this discussion was expanded from "The Retention of the Clinical Scientist" because the recruitment issue was considered critical. Five recommendations were made:

- (1) Look for opportunities to shorten the total length of training from entering medical school to getting advanced research training. There are two components:
 - The three-and-three approach as is carried out at the Washington University where there are three years of medical school, three years of Ph.D. training. In general the effort is to make that experience more relevant and more concise. Any such program must be in accordance with LCME curriculum requirements to complete the same clinical clerkships as are required for all M.D. awardees.
 - Create opportunity for research within the housestaff training yet not lengthen that housestaff training experience. For example, In internal medicine there is a clinical investigator experience that allows for two years of internal medicine training and two years of clinical investigation that leads to board certification.
- (2) Identify the right candidate to pursue these directions from the start, because it is a large investment for the school and the yield could be low unless the candidate search has been selective.
- (3) Protect the time of junior faculty who are recruited specifically as clinician scientists. Although this is a complex issue, young faculty cannot be recruited and given the goal and direction to be a clinician scientist and then be required to spend 75 percent of their time doing something else. There were a number of ideas suggested to accomplish this, including getting start-up money from internal sources that essentially buys the time of junior faculty for a couple of years to get them started.
- (4) Establish a program of active mentoring of junior faculty with specific tasks identified for mentors, especially the responsibility of the mentor to develop an active relationship with the young clinician-scientist. It was stated that there needed to be an annual review process to advise junior faculty as to their progress and to learn of their needs. Such a review should be a genuine two-way discussion
- (5) Establish a program of bridge funding for faculty who have periods of lost funding between their granting periods. It is important to protect them while they get their grants rewritten and back on track.

The Impact of Managed Care Systems

Facilitator: Thomas J. Cinque, M.D.

Reporter: Douglas W. Voth, M.D.

The discussion initially focused on resident recruitment. Many senior medical students are looking for programs where there is greater opportunity to learn about managed care than what they might have seen at their medical school. Many faculty members are not well equipped to help students and trainees learn much about managed care. Community physicians may or may not know more about it, but they are perhaps less interested in the educational activity overall. Even if they are recruited to be more involved, they are not particularly interested in spending more time educating about managed care or other issues either.

HMO developments are occurring without a lot of university leadership. The consequence is that nonfaculty providers, the physicians who are practicing everyday, and the insurance carriers and others who are accepting greater risks than medical schools, are in a leadership and driving position, and most faculty clearly do not perceive this change. The education, training and maturation of faculty to prepare them better to do this seems to be going on at different rates.

Extramural developments in capitated and other forms of managed care are more advanced outside of the university. Many schools are experiencing HMOs and other systems recruit the medical school faculty -- sometimes at substantially higher salaries, with a better definition of their job requirements and more time to have available for freedom and other pursuits.

Acquisition and dominance of networks seem to be fundamental in managed care and capitated systems. Some schools seem to be doing it reasonably well; others are lagging somewhat behind. A number of factors are involved:

- Many participants expressed how they are utilizing their general internal medicine faculty as the primary care personnel who are mostly involved in gatekeeping and primary care practicing.
- Others are purchasing practices, mostly family physicians, but with a wide range of primary care.
- Others are hiring community generalists.
- Some are owning and operating total systems--some pretty well developed and others just beginning.
- Some are striving to merge with practice organizations that are successful
- Some are attempting to keep various practices, but with a varying degree of independence and the assumption of risk.
- Some are using very well larger HMOs and managed care systems to assign various categories of personnel for educational roles and for learning -- for faculty and administrative staff learning, but that point was not discussed in detail.

Medical schools will need relief from the federal government regarding anti-trust and restraint of trade issues because they very much impede progress in this area of aggregating and acquiring practices.

Despite the apparent success of many HMOs, the assembly line of medical care is unattractive to many faculty. Many faculty who have been recruited into these systems and patients do not like it. However, it certainly is what is happening because it seems to be costing less and cost now is driving the system more than anything else.

Some of the other requirements for network development:

- First of all, money. The stability and high quality of the university affiliate are important assets. But deans are not universally assured in the strength of using this as a base. Some feel more confident that they can handle this and can easily negotiate and sell opportunities for primary care people with their own university systems. Others were somewhat tentative.
- The use of restrictive covenants and employment contracts is quite commonplace and may or may not be helpful. It's also very clear that the prompt decision-making and rapid flow of dollars and early contract approval is necessary in order to make these arrangements meaningful and binding.
- Many expressed concern about downsizing subspecialty faculty programs and the number of trainees, although it was noted that perhaps the number of trainees should get downsized. There was great concern about how to do that. It seems as though everyone felt this was something that had to occur, but mostly, but it would be other fellows who would be doing it.
- All faculty and trainees need to become drastically more disciplined or they are not going to survive. They must be restrained in costing out their various services, and patients will have to be placed first. Patient-centered activities seem beyond reach in many instances and satisfaction by the patient and by those who pay the bills, meaning mostly the risk takers, is something that academic medical faculty still have to work on to a great extent.

In summary, clinical education is tied directly to compensable clinical encounters. It is a struggle for each school in one way or another. Times are tough; there is no guaranteed supply of patients, let alone the paying patients. Each school is different -- 126 different places with opportunities, barriers, restrictions, impositions and demands that are really not the same. Each approaches it with increasing commitment, but varying success. Medical schools have a long way to go.

From the variety of ideas expressed by this group, it is clear that there is a multitude of things happening in all of these communities. People are having different experiences and there is no place for all deans to learn from each other some of the things that are happening that might be helpful. Perhaps data about the cost of ambulatory care could be included in the current survey asking about the clinical practice revenue to support the need for the third fund.

Integration of Practice Plans and Multi-Specialty Group Plans

Facilitator: Karl P. Adler, M.D.

Reporter: George M. Bernier, Jr., M.D.

This group obviously overlapped with the managed care group. There is a spectrum of medical school practice plans which extend from departmentally-based, totally independent plans to federated plans to ultimately school-wide, integrated multi-specialty group practices. Of the deans who were present, there were seven (7) who represented totally independent organizations, fifteen (15) federated and six (6) fully integrated. Managed care is driving each institution to become more and more integrated and to become a seamless care provider.

The structure of the plan does not guarantee that the desired outcomes are going to be effected. Major cultural changes will have to occur in a significant number of places for the goals of a seamless provider to be achieved. The comment that "you can't run a clinical business with 15 CEOs" is absolutely true in the present environment. Deans recognize that some institutions, notably the Mayo Clinic, have achieved or were born with both the organization and culture to provide the patient-oriented, seamless services to succeed or even to cope with the new environment. Most schools have dealt poorly with the integration of primary care and primary care practitioners into their academic base. Many think, however, that there is a real opportunity because if primary care providers are faculty of a medical school, they have a voice in what happens. In contrast, the concern is that in most HMOs they really do not have a significant voice.

To be successful, many felt that the role of the departmental chair and the role of the dean will change and that a CEO of a multi-specialty group practice and the dean will, to some degree, co-manage to set salaries and goals of faculties. Departmental chairs ultimately will become far more focused on the role of academic leaders rather than that of CEOs of a small business. The problem will be how they will retain authority in this situation. Whatever structure evolves or is imposed, up-front support of the academic mission has to be established or the academic base will rapidly erode.

Finally, the establishment of physician hospital organizations (PHOs) which many are involved with, is viewed as being a beginning but will rapidly involve into a much bigger system.

Health Outcomes/Quality Research

Facilitator/Reporter: Laurence J. Marton, M.D.

The group looked at the reality of the dawning of a era of new area of investigation and research. Although there have been people who have been toiling in this area for some time, to a great extent they have toiled on the periphery. The question is how do deans as facilitators of research at their institutions craft a setting in which health outcomes research and all of its entities can be vital and something with which deans can feel comfortable including at their institutions. A number of aspects were discussed.

One is the definition -- what should be included in this area? The group took the approach that it ought to be a fairly inclusive definition. It certainly includes clinical outcome research, but not practice economics. On a broader level, health policy is inclusive as well, so the group took the broad definition.

The next point examined was is it correct to do? Can medical schools grant academic legitimacy to those investigators who choose to participate in this area of endeavor? The level of intellect required to do really first class research in this area in some ways exceeds that of the kind of intellect necessary in the molecular biology lab. Molecular biology is a well-defined discipline now; tools and techniques are there, companies are available to do what is wanted; DNA sequencing labs and everything needed are available to the researcher. This discipline, however, is an evolving area, the techniques are not well defined, the approaches that need to be taken are things that need to evolve, and it requires real insight and real intellect. It was the sense of the group that this is something that should be granted academic legitimacy and should be supported.

On the quality of research, there was a recent article in *Science* questioning the approach that has been taken by health care investigators with regard to the legitimacy of the data sets that were used to draw conclusions which have had significant impacts on the directions schools take. Although there may be some reality to that criticism, it is a complex discipline, the techniques are evolving, the data sets are not there yet. They are part of the infrastructure that must be created if indeed this is to become a real discipline. Certain things are essential:

- Needed are the informatics sub-structure, databases, appropriate statistical back-up, etc. If young people enter this discipline as opposed to just those who are presently in it, then training must be provided for those researchers. This is not something which can be done casually. Deans must understand that this is not something that resides only within the medical school. This is something that will cause them to interact with other disciplines such as health policy, economics, industrial engineering, law, business, sociology, ethics, and, very importantly, the area of prevention, and certainly other health care providers.
- Deans must insure that the research has local relevance and activities are implemented locally. The reality is that in this discipline, people have waxed wise, and they have done things, and they have published them in academic journals, but they have looked to others to implement. When implementation was not good, they always had the excuse of "well we didn't do it, and therefore, they didn't have our insights and it wasn't implemented well." Deans must take the risk of implementation if they are going to do the science. If the way medicine is practiced does not change, then this will remain a strictly academic

discipline. Part of the pressure for funding and part of the pressure to move more people into this discipline requires that in fact, the practice of medicine changes. Medical schools should become leaders in changing the way medicine is practiced.

- Practice guidelines are being produced by a variety of institutions and organizations. The cost of care is being looked at much more importantly than the correctness of care. One of the great disappointments that many deans have with health care reform is not that it should not take place, but that cost is the driving force. Economics are important, but there is a legitimacy to health care reform that says medicine is not doing the best it can and that issue should be the driving force. In fact, as these studies are conducted, it may be determined that physicians are not just not over-utilizing, but in fact in certain areas, they are under-utilizing. That would give deans the ammunition to fight for renewed resources in order to provide the appropriate kind of health care. Deans need to take the lead.
- Finally, a couple of relatively simple recommendations to think about in terms of how to craft this. One is that many institutions probably do not have the resources to do this themselves but would be significant contributors to an entity that was crafted by a consortium of institutions. This was a suggestion that was made and one that the AAMC might be able to assist with in terms of setting up symposia, interaction groups, etc.

In addition, there is a lack of information that presently exists and it may be useful for the AAMC to consider creating a little handbook of what is being done, where it is being done, who are the people involved, what are the methods being utilized, what are the problems that are faced and, importantly, what are the funding sources.

An additional point was on what the roots of medicine are. Medicine has been considered as having its roots in science and a dominant theme of the group discussion was that the roots of medicine as it is taught and practiced are certainly in biologic sciences as deans know and appreciate them. There is another root system of this tree, however, which speaks to the academic legitimacy and importance of creating that arena of thought and activity within the whole construct of medical education. The discussion went a bit beyond even the topic itself to wax philosophically about what constitutes medical education. As medical schools redefine themselves, they are redefining the profession as well. The roots of the profession have to be redefined and the construct of medical education with an eye on the product has to be looked at even more, therefore giving credence to the importance of this arena of thought and its legitimate incorporation into the structure of medical schools. The group gave high priority to that aspect, not as an adjunctive activity of medical schools, but in fact as a root structure within the framework of medical schools.

Primary Care Curriculum and the Education of Generalist Physicians

Facilitator: Robert C. Talley, M.D.

Reporter: Theodore Booden, Ph.D.

The group agreed to focus its discussion on undergraduate education (although there was some support for considering and evaluating residency training) with respect to increased exposure to what generalists do and to look into the knowledge, skills and attitudes that are pertinent in the training of generalists.

In terms of undergraduate medical education, the group concluded that if deans are to facilitate the increased awareness of students as to generalist medicine and to what generalists do, they should take the following steps.

- Students have to become more aware of what generalists and primary care physicians do. Schools must expose them to the proper role models and mentors early in their medical school career. Students should be allowed to experience continuity care, holistic medicine and the health care needs of the community *per se*. They must deal with the reality of everyday medicine, the common kinds of problems that people face in their everyday lives, that medicine in a generalist fashion deals with birth-to-death medicine overall. Included should be consideration of the role of non-M.D. primary caregivers, PAs (physician assistants) as such, nurse practitioners, etc. and their roles in the health care system. Medical school students should be made more aware of what these people do.
- Schools have to strive to bring more humanism into medicine--what humanism is and how they can achieve their goals in dealing with the common problems of people through developing proper behavioral skills.
- A theme that came up in a number of points during the discussion was that students need to be taught to deal with uncertainty. As one person said, there seems to be two mindsets out there: the generalists deal or cope with uncertainty while specialists strive to eliminate uncertainty. Students ought to be exposed to the reality and the sensitivity that uncertainty is a very real part of medicine and that it is okay to live with uncertainty and that uncertainty can be dealt with in an effective way. To help students deal with uncertainty, some suggested that schools ought to provide them with a better understanding of outcome analysis to deal with public health issues, decision analysis, cost analysis, and, importantly, to deal with uncertainty through subjects related to bio-ethical issues and common problems facing people when life and death decisions are being made.
- The students need to be taught to respect the prerogatives of the patient. Physicians have to do a better job at trying to deal with the wishes, the desires, the feelings of people. There seems to be too much of a mechanistic approach at times in our education. Through the basic sciences and through the clinical years, students are constantly being taught to solve the problem, to come up with better ways to deal with the problem, but more time must be allowed for them to understand the nature of the people that they're dealing with as people. Students have to learn to listen better as people talk about their conditions and not only to listen to their medical complaints, but how do they feel in general.

- There's a sense that to accomplish this, there has to be an increased role for behavioral sciences in the training of medical students. The students must become comfortable dealing with non-organic problems, as well as trying to deal with organic illness. Students have to understand that in everyday life, there are consequences as a result of stress and depression and problems and just existing.
- The educational system must openly value the role of the generalist. There must be a sense that these physicians have earned their respect, that they do a significant job out there. There cannot in the process, on the other hand, be a reduction in respect for specialists.
- There was a sense that students need to be adequately exposed to ambulatory medicine, utilizing community hospitals to a greater extent, and there must be an increased use of the generalist in the overall educational process. But in doing that, there is a need for quality assurance, something that all will have to remain vigilant with when students are getting beyond the campus. Schools must be able to measure the outcomes. We must be able to evaluate whether we are achieving our goals when our students are encountering these new experiences.

There were some bullet comments that were made during the session:

- Changes in curriculum result in gainers and losers. Additions of community-based ambulatory curricula require that many hours (perhaps as many as 180) must be scheduled into the curriculum and who is going to give up that time? Deans cannot just keep adding things to the curriculum without subtracting things from the curriculum.
- Faculty development is going to be essential in this process. There must be an effort to retool or retrain or expose faculty to understand that when deans are trying to make these changes in curriculum, they are a key element, and they need to have a better sense of where the dean is going and why he/she wants to do these things.
- There was a comment made that Canadian schools have similar curricula to the U.S. schools and they turn out more generalists than we do. Maybe deans should ask how come? Perhaps one answer is it is part of their culture. That is what they do and they continue to do it.
- There were requests that behavioral sciences ought to increase in terms of exposure in a curriculum to facilitate students looking toward generalism.
- There was a sense that the AAMC ought to develop programs, perhaps a symposium, on dealing with the training of the generalists.
- Then there was the comment, which all expect, that the marketplace will decide the issue for medical schools. If deans allow that to happen without intervening, it will decide a lot more drastic things for medical schools.
- The last thing is hope. Medical schools will maintain the balance. They are good at that and they will continue to strive for it.