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ISSUES

POLICIES

PROGRAMS

OF THE

ASSOCIATION OF

AMERICAN MEDICAL COLLEGES

AN AAMC WORKING PAPER

April 1974

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Founded 1876

"The purpose of the Association is the advancement of medical education. In pursuing this purpose, it shall strengthen, expand, and cooperate with all educational programs that are important to the nation's health, with particular concern for the entire span of education and training for the medical profession and health sciences. The Association will foster studies and research, provide means of communication and forums, and perform services necessary to program and policy decisions that the above broad objectives require."

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FOREWORD

This publication has been developed by the staff of the Association of American Medical Colleges in response to a recommendation of its Council of Deans and Executive Council. The document presents:

1. the major issues which the Association faces as the national representative of U.S. medical schools and teaching hospitals;

2. the Association's current policy or steps to develop policy on each particular issue; and

3. AAMC activities undertaken in an effort to achieve the goals related to those policies.

In response to a proposal developed by the Council of Deans at their 1973 spring meeting in San Antonio, the COD Administrative Board recommended that the staff prepare "a new document setting forth a summary of where the AAMC stands on major issues facing the Nation in the areas of medical education, biomedical research, delivery of health services, and the financing of these activities...." The Board also specified that the document clearly define AAMC efforts toward policy formulation and progress toward identified goals. At its June 22, 1973 meeting, the Executive Council adopted the recommendation of the COD Administrative Board.

This working paper will be presented to the Council of Deans at their 1974 spring meeting, and to all AAMC Administrative Boards and the Executive Council in June. If the document is approved at that time, it will be published for distribution to the constituent members of the Association. Additional distribution, if any, of the final publication will be determined by the Executive Council.

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I. QUALITY OF MEDICAL EDUCATION

ISSUE: HOW AND BY WHOM SHOULD ACCEPTABLE QUALITATIVE LEVELS OF EDUCATIONAL PROGRAMS BE ASSURED?

PRESENT STATE OF POLICY DEVELOPMENT:

The primary responsibility for assuring that educational programs are of acceptable quality rests with each institution. It is a responsibility borne primarily by its faculty exercising its collective academic judgment in the design and implementation of the curriculum, the assignment of competent educators, the selection of capable students and the evaluation of their performance. The institution is assisted in gauging its own performance through the availability of external assessment procedures and instruments.

Accreditation of institutions and education programs is the primary instrument developed by the institutions and the professions as a means of external review, monitoring and assessment of the institutional or program quality. As it has evolved, accreditation brings to bear the disinterested expert judgment of outside professionals and academicians, leavened by the perspective of informed public representatives. Its purpose is to assure the institution that its resources are adequate to serve its objectives and directed toward their achievement, to assure applicants and students that their education can be successfully pursued in the institution, and to assure society that its resources are appropriately utilized and the graduates of the institution are qualified according to their credentials.

The AAMC Assembly approved the revised "Function and Structure of a Medical School" in 1972, setting forth the criteria to be used in the accreditation of medical schools.

PROGRESS TOWARD ACCOMPLISHMENT:

Two parallel efforts are underway to achieve the purposes and objectives of accreditation as a guarantor of educational program quality. The first is directed toward refining the sophistication of the process of accreditation; it involves the development of more appropriate organizational forms--the formation of the CCME, the LCGME and progress toward an LCCME to complement the role and function of the LCME--the refinement of the accreditation standards--the Function and Stucture of a Medical School, the Criteria for Programs in the Basic Medical Sciences--the development of more appropriate assessment procedures and instruments--the exploration of the use of the self study protocol, the refinement of data collection instruments.

The second involves defending the integrity of voluntary accreditation from encroachment and dismantlement by the Federal Government and zealous critics of the system. This has entailed a review, critique and negotiations for revisions in the OE draft Criteria for Recognized Accrediting Agencies, comments on the SASHEP Report, review and comment on the Newman Report, "National Policy and Higher Education," and the Brookings Institution (Orlans) report, "Private Accreditation and Public Eligibility."

AAMC DEPARTMENT PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE:

LCME, LCGME, CCME (AAMC participates in these conjoint committees)

ISSUE: SHOULD SOCIAL POLICY AND ETHICAL CONCERNS OF SOCIETY BE ENFORCED THROUGH THE ACCREDITATION PROCESS?

PRESENT STATE OF POLICY DEVELOPMENT:

Ethical concerns are an integral part of any professional education program; ethical standards are inculcated through precept and example. To the extent that institutional behavior impinges upon the quality of an educational program, it is a matter of legitimate and appropriate concern of the accrediting body and process. On the other hand, it is the policy of the AAMC, supported and implemented by the LCME, that other more appropriate means are available to assure compliance with public policy and that any effort which would subvert the purpose of accreditation to the implementation of societal goals other than the assurance of program quality - no matter how laudatory - should be vigorously opposed. While it is clear that the standards, policies and procedures for accreditation cannot conflict with, or subvert, public policy asperations expressed in law, whether statutory or judicially established, it should be equally clear that accreditation cannot bear the burden of a requirement that it be a catch-all instrument of enforcement with respect to academic institutions. Its mission in society is the assessment of the quality of education and training programs.

PROGRESS TOWARD ACCOMPLISHMENT:

The work of the LCME is carried on against the background of this policy with an acute sensitivity and awareness as to what extent ethical practices impinge upon the quality of education. This policy is constantly being tested in day to day operation. Legitimate ethical concerns for accrediting bodies are, for example, those which delineate the organization, responsibilities and privileges for the administration, faculty and students that there be no discrimination in admissions or employment on the basis of sex, creed, race or national origin. Institutional practices regarding human experimentation and animal care facilities illustrate two other types of ethical considerations which can impinge on the quality of the educational program.

The question raised by the issue set forth above is directed toward the use of the denial of accreditation as an enforcement instrument of social policy. This explanation of progress reflects the kinds of issues which confront the accrediting agency on a continuing basis as it proceeds to guarantee an acceptable level of quality in medical education as a public responsibility.

Outside the context of accreditation the AAMC can and is directing considerable effort to assisting its constituency in such areas as minority students, affirmative action, human experimentation, etc. If an institution has impeccable practices and procedures carefully observed, these matters will cease to receive undue attention in the accreditation arena.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Institutional Development

AAMC COMMITTEE:

LCME, CCME, LCGME (AAMC participates in these conjoint committees)

ISSUE: SHOULD THERE BE A NATIONAL EXAMINATION REQUIRED FOR ALL AT THE INTERFACE BETWEEN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION?

Entrance into graduate medical education for U.S. medical students has only required the satisfactory completion of a course of study and the awarding of an M.D. degree by an accredited medical school. Although some graduate medical institutions and some states have required that residents be licensed and thus have required the passing of a licensing exam such as the NBME exam, the FLEX exam or state licensing board exam, there has been no uniform, national requirement for all students who enter graduate medical education to pass a qualifying exam.

PRESENT STATE OF POLICY DEVELOPMENT:

In March 1974 the Executive Council approved the FMG Task Force report which recommends ". . .that a generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until another such examination may become available, Parts I and II of the National Board Examination should be employed for this purpose."

The National Board of Medical Examiners established a Committee on Goals and Priorities in 1971. The Committee report entitled, "Evaluation in the Continuum of Medical Education," was released in June 1973. This report recommends the development of a qualifying exam required for all who enter graduate medical education in the United States whether they have received their M.D. degree from a domestic or foreign school. This report was received by the NBME and has been under intense study during the subsequent 10 months. The NBME does not plan immediate implementation.

The Executive Council has established a Task Force to analyze the Goals and Priorities Committee report and recommend to the Executive Council a position on this issue.

PROGRESS TOWARD ACCOMPLISHMENT:

The FMG Task Force report has been distributed to the constituency for reaction and comments.

The Task Force on the GAP Report will hold its meetings during the Spring of 1974. In December of 1973, a committee requested by the Group on Medical Education to explore the reactions of the schools and the faculties of the GAP Report was convened. This committee held meetings in all four regions and has produced a set of working papers which will be utilized by the Task Force in analyzing the CAP Committee report. There are numerous position statements and resolutions which have been received by the Association from medical schools and from academic societies. All of these communications are being collated and will be utilized by the Task Force.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Department of Institutional Development

AAMC COMMITTEE:
FMG Task Force--discharged
Ad Hoc Task Force on the NBME-GAP Report
CCME

ISSUE: SHOULD THE AAMC ASSIST MEDICAL SCHOOL FACULTIES IN IMPROVING THEIR CAPACITIES TO MEET THEIR GROWING EDUCATIONAL COMMITMENTS?

This is a time when faculty members in our medical schools are being called upon to educate increasing numbers of students, without comparably increased numbers of faculty or enlarged resources, while assuring that there is, at the very least, no decrease in the quality of the educational product. At the same time, it is being increasingly recognized that although instruction is the primary responsibility of medical school faculty members, it is the responsibility for which they are least prepared.

PRESENT STATE OF POLICY DEVELOPMENT:

Until the present, the AAMC has done little, if anything, in the area of direct assistance to faculty in the improvement of their capacity as instructors. In March 1974, the decision was made to establish a new Division of Faculty Development, which will begin to function on September 1, 1974. It will be the responsibility of this Division to devise methods and develop services which will assist faculty members of medical schools in improving their effectiveness as teachers, and in the efficient use of their instructional time.

PROGRESS TOWARD ACCOMPLISHMENT:

A Director for the Division of Faculty Development has been identified, a basic budget for the establishment of this new unit has been secured, and funding proposals are being prepared for submission to foundations and agencies. As soon as funding is assured, active recruitment will be undertaken for additional staff for this Division.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Faculty Development of the Department of Academic Affairs

AAMC COMMITTEE:

ISSUE: SHOULD THE AAMC PLAY AN ACTIVE ROLE IN IMPROVING THE ACCESSIBILITY AND EFFECTIVE USE OF MULTI-MEDIA EDUCATIONAL RESOURCES?

The increased development of educational technologies has provided an ever increasing universe of multi-media learning materials to assist medical school faculties in their teaching of increasing numbers of students. These same technologies have provided students with an opportunity to better realize a more individualized medical curriculum and to enhance the development of their skills in self-education, self-evaluation and communication. Problems relating to the use of multi-media educational material include: the absence of an efficient clearinghouse for evaluated materials; the availability and shareability of these materials by institutions in subject areas of preceived need; the varying abilities of faculties and students to utilize these materials effectively and the irregular patterns of quality and cost.

PRESENT STATE OF POLICY DEVELOPMENT:

A workshop was held February 1969 entitled "Potential Educational Services From A National Biomedical Communications Network." Subsequently, the AAMC Biomedical Communications Network Steering Committee was established in 1969. A series of recommendations were presented to both the NLM and the academic community defining the roles and responsibilities of both the academic community and the Federal Government in enhancing the uses of educational technology in medical education. Reports were published as supplements to the Journal of Medical Education: Educational Technology for Medicine: Roles for the Lister Hill Center (J. Med. Educ., 46: July (Part 2) 1971) and Educational Technology for Medicine: Academic Institutions and Program Management (J. Med. Educ., 48: 203-226, February 1973).

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC Division of Educational Resources was established in 1973. A contract from NLM permitted the initiation of the AAMC/AADS Educational Materials Project. The five basic programs include: the development of a system for the appraisal of educational materials in nontraditional formats (audiovisual, computer-based instruction, simulations, etc.); the development and implementation of a clearinghouse system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by students and faculties; and other areas of mutual concern regarding the uses of educational technology in health science education. A grant from the Kaiser Family Foundation and Commonwealth Fund has permitted a feasibility study to explore the development of a national institutional model to enhance the use and effectiveness of multi-media learning systems.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Educational Resources

AAMC COMMITTEE:

AAMC/AADS Educational Materials Project Advisory
Kaiser/Commonwealth Feasibility Study Advisory Panel

II. UNDERGRADUATE MEDICAL EDUCATION

ISSUE: SHOULD CLINICAL EDUCATIONAL PROGRAMS IN DIVERSIFIED SETTINGS BE ENCOURAGED?

The ambulatory care function of the academic medical center takes place in a variety of settings, the most universal of which are outpatient departments and emergency services. Others include neighborhood health centers, C and Y clinics, group practices and HMOs. Settings in which quality primary care is delivered are considered to be appropriate sites for primary care training programs. To meet the increased need for appropriate primary care, academic medical center faculty involved in the delivery of primary care must integrate ambulatory service and teaching into effective training programs.

PRESENT STATE OF POLICY DEVELOPMENT:

The Functions and Structure of a Medical School, prepared by the LCME and ratified by the Assembly in November 1972, states, "Instruction should be sufficiently comprehensive so as to include the study of both mental and physical disease in patients who are hospitalized as well as ambulatory."

AAMC testimony on area health education centers and health maintenance organizations has requested support for the development of physician training programs in a variety of organizational frameworks and different health care facilities.

PROGRESS TOWARD ACCOMPLISHMENT:

A survey of the schools in 1973 revealed that undergraduate students have on the average only 2 months of clinical experience in ambulatory settings. Beginning May 1, 1974, through a contract with the Bureau of Health Resources Development, a pilot program to develop physician training programs in HMOs will be started.

A second proposal was submitted to BHRD in March 1974 which outlined a two-and-a-half-year project to assist academic medical centers in developing, implementing and evaluating primary care training programs in a variety of ambulatory settings at both the graduate and undergraduate levels. The project will involve 4-6 constituent institutions and will attempt to determine the cost effectiveness of the different training programs.

A Primary Care Institute will be held in October 1974. Its focus will be on the organization of optimum settings for primary care training programs. This three-day invitational conference will be attended by deans and chairmen of medicine, pediatrics, family medicine and others.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE: Task Force on Primary Care

ISSUE: TO WHAT EXTENT SHOULD QUALITY OF CARE ASSURANCE PROGRAMS BE INTEGRATED INTO CLINICAL EDUCATION?

Inasmuch as quality of care should be a major concern of practicing physicians, there is a need in academic medical centers to involve medical students and house staff in medical care evaluation programs during their training period. These programs in quality assessment and assurance should take place within both the didactic and clinical portions of the curriculum, and should prepare students to accept peer review of their professional activities with equanimity.

PRESENT STATE OF POLICY DEVELOPMENT:

In March of 1973, the Executive Council approved 5 propositions on which to base a new thrust in continuing education. The first of these states, "The medical faculty has responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to demonstrate that they are competent to deliver care to patients throughout their professional lives."

At the same meeting the Executive Council approved and adopted the following statement:

> "The AAMC believes that the development and implementation of norms and standards for assessing the quality of health care is a vital responsibility of the medical school faculty and organized staff of the teaching hospital. A major part of this responsibility is the incorporation of quality-of-care assessment into clinical educational programs to develop in medical students and residents a life-long concern for quality in their practice."

PROGRESS TOWARD ACCOMPLISHMENT:

At the Annual Meeting in 1972, presentations were made to the Councils regarding the potential impact of the PSRO amendment in the Social Security Amendments of 1972. The desirability of having academic medical centers become engaged in quality of care assurance programs and integration of these programs into their educational system was emphasized. There has been no organized plan to proceed with these efforts.

The AAMC is presently exploring the feasibility of contracting with the DHEW to develop models for integrating evaluation into medical school curricula.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE: Health Services Advisory Committee/Subcommittee on Quality of Care

ISSUE: SHOULD THE AAMC ENCOURAGE THE INVOLVEMENT OF UNITED STATES MEDICAL SCHOOLS IN INTERNATIONAL HEALTH?

United States medical schools with the assistance of AAMC are making serious efforts to develop community medicine and primary care as major academic programs. Opportunities for experience in international health may be an important adjunct to this effort. If an experience abroad is well-planned, it can impress on the student the responsibilities of the physician in developing comprehensive community and personal health services.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association established and maintains a Division of International Medical Education to encourage and assist medical schools in becoming more involved in international health.

PROGRESS TOWARD ACCOMPLISHMENT:

Many schools conduct education programs in international health offering senior students a one to three month experience abroad. AAMC also has administered a national fellowship program for medical students in collaboration with Israeli and Yugoslav faculty. In view of the widespread activities and interests, general guidelines entitled, "Essentials of Programs for Education in International Health," for the planning and administration for such programs are under preparation. It is proposed that the educational sequence outlined in these "Essentials" may be acceptable in total or in part as an adjunct to education programs in community medicine and primary care.

In addition, the AAMC maintains contact with the Liaison Officers for International Activities at each medical school, and assists them wherever possible. Through the Association, deans and faculty members have been actively involved in the Pan American Federation of Associations of Medical Schools, the Association of Medical Schools of Africa, and related international activities.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of International Medical Education

AAMC COMMITTEE:

Committee on International Relations in Medical Education and an advisory group chosen from the Liaison Officers for International Activities

III. GRADUATE MEDICAL EDUCATION

ISSUE: SHOULD THE MEDICAL SCHOOLS ASSUME INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION?

The medical schools have increasingly become engaged with graduate medical education, and most schools have as many or more interns or residents as they have undergraduate medical students. However, the responsibility and authority for these programs is divided among the many department heads inthe clinical disciplines and is further divided among the several hospitals which make up most academic medical centers. The issue revolves around having the academic medical centers develop systems which make the entire faculty responsible for graduate medical education and provide for overall administration of graduate programs by the academic medical centers' administrative teams. The dean of the medical school would thus have a far greater role in planning and developing graduate programs for residents.

PRESENT STATE OF POLICY DEVELOPMENT:

By action of the Assembly in 1971, a position statement (published in AAMC Bulletin, Nov. 15, 1971) recommends that the academic medical centers assume responsibility for graduate medical education in a fashion analogous to that for which they have responsibility for undergraduate medical education. This implies that the faculty of the institutions as a whole should assume responsibility for planning and evaluating the graduate programs of instruction and should set the standards for student selection, progress and certification for readiness to be examined by specialty boards. The program further recommends that freestanding hospitals desiring to continue or develop graduate medical education programs should seek affiliation with university academic centers or should develop sufficient resources to permit their being accredited as freestanding graduate medical schools. This position statement was evolved subsequent to a conference of the Council of Academic Societies in 1968; the proceedings were published as a special issue of the Journal of Medical Education (J. Med. Educ., 44: September (Special Issue) 1969). A committee chaired by Thomas Kinnedy published the IMPLICATIONS document (J. Med. Educ., 44: 77-84, February 1972).

PROGRESS TOWARD ACCOMPLISHMENT:

The Graduate Medical Education Committee, chaired by William G. Anlyan published a supplement to the Journal of Medical Education entitled "Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education" (J. Med. Educ., 48: 780-791, August 1973). There has been a heavy reprint demand for this document and many schools have indicated that they are having faculty retreats and administrative discussions regarding plans for increasing institutional responsibility for graduate education. A few institutions have developed proposals which are under active discussion. A major problem regarding moving toward assuming institutional responsibility is the issue of how to finance graduate medical education. The CCME has adopted a statement which incorporates the principal recommendations of the AAMC position statement.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services; Division of Student Studies

AAMC COMMITTEE: Graduate Medical Education Committee

ISSUE: SHOULD ACCREDITATION OR OTHER EXTERNAL MECHANISMS BE USED TO REGULATE THE NUMBER AND DISTRIBUTION OF RESIDENCY POSITIONS?

Residency and fellowship positions in the specialties and subspecialties have never been subject to quantitative controls. The number of programs currently existing is a result of multiple idenpendent decisions by hospitals and program directors. The Boards and the Residency Review Committees have no policies relating to the number of specialty programs in the United States.

PRESENT STATE OF POLICY DEVELOPMENT:

One of the implications of the institutional responsibility statement is that the institutions should assume responsibility for determing both the types of residency and fellowship programs they will sponsor and the number of students they will enroll. The Graduate Medical Education Committee recojmended in it informational report to the Executive Council in December 1973 that the schools and graduate programs should set a goal of enrolling and retaining 50% of graduating medical students in the primary care specialties of family medicine, general medicine and general pediatrics. The issue of using the accreditation mechanism for limiting the number of graduate programs has been discussed informally at several levels, including the CCME's Ad Hoc Committee on Physician Distribution.

In March 1974, the Executive Council approved the FMG Task Force Report which recommended ". . .that the number of first year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools, but provide sufficient opportunities to highly qualified FMGs."

The AAMC National Health Insurance Task Force, as part of its recommendations to the Executive Council, has proposed the creation of a national body "to determine the number and location of resident positions in the various medical specialties." National needs would govern this determination and residents in unapproved positions would be ineligible for reimbursement under national health insurance.

PROGRESS TOWARD ACCOMPLISHMENT:

The CCME Ad Hoc Committee on Physician Distribution will report to the CCME sometime during 1974. It is anticipated that this report will recommend that at least 50% of graduating students from U.S. medical Schools should be retained in primary care specialties, but it is unlikely that a firm recommendation that a national system for determining the number of residency positions in any specialty will be specified. The Liaison Committee on Graduate Medical Education, as it reviews the quality of the Residency Review Committees' actions, may exert sufficient influence to decrease the number of training programs by eliminating those that are particularly weak. The Graduate Medical Education Committee of the AAMC is continuing to study this issue and has adopted the stance that the total number of graduate medical education positions in the U.S. should be limited to a number in the range of 110 to 120% of the graduating class. Recommendations for how to accomplish this goal have not yet been developed.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Department of Institutional Development

AAMC COMMITTEE: Graduate Medical Education Committee; LCGME, CCME (AAMC participates in these conjoint committees)

ISSUE: HOW SHOULD GRADUATES OF FOREIGN MEDICAL SCHOOLS BE INTEGRATED INTO UNITED STATES PROGRAMS OF GRADUATE MEDICAL EDUCATION AND INTO THE UNITED STATES HEALTH CARE SYSTEM?

in 1972 one third of all enrolled interns and residents in United States teaching hospitals and 49 percent of all physicians receiving state licenses to practice medicine were graduates of foreign medical schools. This disproportionate representation of FMGs represents a threat to quality education and services.

PRESENT STATE OF POLICY DEVELOPMENT:

The FMG Task Force of the AAMC in a report approved by the Executive Council makde the following policy recommendations:

1. For admission to graduate medical education all applicants (graduates of domestic and foreign medical schools) must pass a single examination.

2. Pilot programs with enrolled FMGs should explore their educational defects and ways to correct them.

3. The approval of hospital programs for graduate medical education should be based on sound educational principles and the number of positions available should not exceed to any great extent the number of graduates from United States medical schools.

4. The permanent employemnt of unqualified, unlicensed FMGs should be discontinued even in the institutional setting.

5. Pilot programs should explore the substitution of other means to render services presently provided by FMGs in graduate education programs.

PROGRESS TOWARD ACCOMPLISHMENT:

With the approval of these recommendations by the Executive Council on March 22, 1974, the FMG Task Force Report has been submitted to the AAMC constituency for reaction and comments. Ultimate implementation will depend on constituency interest and participation, and on collaboration with other agencies and organizations.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of International Medical Education

AAMC COMMITTEE:

FMG Task Force--discharged

ISSUE: WHAT SHOULD THE ROLE OF THE AAMC BE IN ENSURING THE VIABILITY AND INTEGRITY OF THE NIRMP?

The NIRMP was established in the early 50's to eliminate an increasingly chaotic competition for first-year graduate training positions. The elimination of an internship as a requirement for certain specialty residencies in the early 70's has resulted in multiple evasions of the program by both program directors and students. The problems are summarized in the article by Joseph Ceithaml, Ph.D., and Davis G. Johnson, Ph.D., "The NIRMP and Its Current Problems" (J. Med. Educ., 48: 625-629, July 1973).

PRESENT STATE OF POLICY DEVELOPMENT:

In 1972 the COD and CAS Administrative Boards expressed concern over NIRMP violations and adopted a statement which was approved by the Executive Council. It stated: "Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, the first hospital based graduate training appointment after the awarding of the M.D. degree should be through the National Intern and Resident Matching Program."

At the request of the Organization of student Representatives and the Group on Student Affairs, an NIRMP Monitoring Program was approved by the Executive Council in June 1973. Announcement of the program was made in Deans Memo #74-7, February 1974. This program provides for reporting violations of the NIRMP to program directors through the office of the AAMC President, and the ultimate reporting of continuing violations to the NIRMP. The Administrative Board of the CAS has recommended the establishment of a Task Force to study NIRMP problems.

The Association, at every opportunity, has expressed its strong commitment to the viability and integrity of the NIRMP.

PROGRESS TOWARD ACCOMPLISHMENT:

AAMC staff have met with representatives of the American University Professors of Ophthalmology and with the American Association of Chairmen of Departments of Psychiatry to identify the basic reasons for the difficulty which these specialty groups have encountered with the NIRMP.

Functional problems in data processing by NIRMP staff have been resolved. The problem of enforcing adherence to NIRMP rules by program directors, hospitals and students is not resolved. The Monitoring Program may be of value, but this cannot be determined until the 1974-75 cycle. The LCGME has established an ad hoc committee to study the issues.

The AAMC President, Dr. Cooper, has accepted the Presidency of the NIRMP for 1974-75, and is committed to improving both the operational and the programmatic integrity of the NIRMP.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Student Programs and Services

AAMC COMMITTEE:

IV. CONTINUING MEDICAL EDUCATION

ISSUE: WHAT IS THE APPROPRIATE ROLE OF THE MEDICAL SCHOOLS IN PROVIDING EFFECTIVE PROGRAMS OF CONTINUING MEDICAL EDUCATION?

Whether sponsored by medical schools, state or country medical societies or national specialty organizations, programs in continuing medical education for practicing physicians rely heavily upon the talents of the faculties of the Nation's medical schools. Because the demand for continuing medical education is rising, it is important that the faculty effort dedicated to this endeavor be as effective as possible.

PRESENT STATE OF POLICY DEVELOPMENT:

In March of 1973, the Executive Council of the AAMC adopted five propositions as the basis for developing a new thrust in continuing education. These were published in Vol. 8, No. 3, of the March 1973 issue of the AAMC Bulletin. The propositions are: 1. Medical faculties have a responsibility to impress upon students that the process of self education is continuous. 2. Medical faculties must cooperate with practicing physicians to develop criteria of optimal clinical management of patient problems. 3. Educational programs must be specifically directed toward improving detected deficiencies. 4. Evaluation of the effect of educational programs should be planned from their inception and should be based upon assessment of the modifications of the physician's day-to-day practice. 5. Financing of continuing education must be based upon a policy which recognizes its essential contribution to the progressive improvement of health care delivery. The Executive Council further recommended that the Group on Medical Education of the AAMC include within its members individuals from the medical schools who have responsibility for continuing medical education.

PROGRESS TOWARD ACCOMPLISHMENT:

The Group on Medical Education has been studying how to incorporate within its membership individuals from the medical schools responsible for continuing medical education.

At the time of the formation of the Liaison Committee on Continuing Medical Education (a committee under the CCME), the Association insisted that the purpose of this Liaison Committee should first be to provide a body for developing new principles and policies for continuing medical education, its supervision and accreditation. It is anticipated that the LCCME will be activated early in 1975.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs

AAMC COMMITTEE: CCME

ISSUE: SHOULD PERIODIC RECERTIFICATION AND RELICENSURE OF PHYSICIANS BE REQUIRED?

During the last five years, there has been an increasing interest by specialty boards and state licensing boards in the concept of requiring that physicians be periodically recertified or relicensed. Recertification or relicensure are generally conceived to be based upon evidence that the physician has participated in continuing education or passed an examination or both. There appears to be a consensus that recertification or relicensure requirements will improve the quality of medical care delivered, even though there is little or no evidence that this will be an outcome of such requirements.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association does not have a policy on recertification or relicensure. A preliminary draft of a position was reviewed by the Graduate Medical Education Committee in early March 1974. The Committee requested that further investigation be done regarding the potential effects of recertification on the day-to-day practice of medicine by physicians. The Committee is also concerned that should recertification and/or relicensure become a commonplace requirement, the demand for educational services from physicians now in practice may increase enormously; and such an increase will require that appropriate planning for expanding educational resources in this country will be needed.

PROGRESS TOWARD ACCOMPLISHMENT:

The Graduate Medical Education Committee will study this issue during the Spring and Summer of 1974. It has been determined that twenty-two of the twenty-three specialty boards are seriously considering recertification and that two states have already adopted laws requiring relicensure. The American Board of Internal Medicine is offering a voluntary recertification exam in the Fall of 1974; the American Board of Family Practice will require a recertification of all of its diplomates in 1976; the Board of Opthalmology is considering a voluntary, self-assessment exam in 1975 as is the Board of Thoracic Surgery; the American Board of Surgery plans mandatory recertification for all those certified after September 1, 1975, on a ten-year cycle.

All bodies currently concerned with recertification are uncomfortable with basing recertification solely upon passing a cognitive examination. Efforts to identify methodologies to assess competence are going on in several quarters, including the AAMC's Division of Educational Measurement and Research and the National Board of Medical Examiners.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Educational Measurement & Research

AAMC COMMITTEE: Graduate Medical Education Committee

V. INSTITUTIONAL CONSIDERATIONS

ISSUE: WHAT FACTORS SHOULD DETERMINE THE RATE AND EXTENT OF FUTURE EXPANSION OF MEDICAL SCHOOL CLASS SIZE?

The Comprehensive Health Manpower Training Act of 1971 established enrollment expansion as a prerequisit for federal capitation support. Medical Schools responded to this incentive by dramatically increasing class size. As renewal of this legislation is debated, the issue of whether additional enrollment increases whould be federally-mandated has surfaced.

PRESENT STATE OF POLICY DEVELOPMENT:

Although in 1968 the AAMC and the AMA jointly endorsed the position that medical schools should "accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted," this position was soon afterward considered to be impossible to attain. In 1970, the AAMC, following the recommendations of its Committee on the Expansion of Medical Education (Howard Committee), modified this endorsement to propose that by 1975, medical school first year enrollment should increase to 15,000 students, and be maintained at that level. This was felt to be sufficient to overcome the shortage of physicians. (See J. Med. Educ., 46:105-116, Feb. 71)

The AAMC currently supports expansion of medical school class size in relation to the need for physicians. The Association recognizes that determining the need for physicians is a complex question which must take into account problems of geographic and specialty maldistribution. However, because of limited financial resources for medical education and in an effort to maintain quality in education and care, the Association believes that medical school enrollments should increase only to reflect the nation's requirements for physicians.

PROGRESS TOWARD ACCOMPLISHMENT:

The Howard Committee goal of an entering class of 15,000 student by 1975-76 will most likely be met. The Association, in discussions with federal policy-makers, has opposed measures which would require expansion regardless of future manpower projections.

The Association is attempting to identify physician manpower studies which might contribute to the current perceptions of physician need.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

ISSUES: WHAT IS THE APPROPRIATE DISTRIBUTION OF EFFORT IN ACADEMIC MEDICAL CENTERS BETWEEN HEALTH SERVICES ESSENTIAL TO EDUCATION AND HEALTH SERVICES UNDERTAKEN IN RESPONSE TO OTHER SOCIAL NEEDS?

Academic medical centers have offered a broad range of inpatient and ambulatory services, primarily as an outgrowth of the educational process. These services have had an increasing impact on the communities in which they exist. Questions arise as to the extent of the center's responsibilities for developing educational and service programs reflecting local needs and resources.

PRESENT STATE OF POLICY DEVELOPMENT:

Because of the great variation in medical center settings, this issue must be addressed by each constituent institution, taking into account local needs, resources and interests.

PROGRESS TOWARD ACCOMPLISHMENT:

To assist the institutions establishing these policies, two major staff activities are underway:

1. The Health Services Advisory Committee is presently considering this problem from three perspectives:

   a.) The roles of faculty

   b.) Determination of program responsibilities for patient care and community service.

   c.) The types of governance structures that would resolve these issues.

2. The AAMC Management Advancement Program and related institutional studies are directed toward the determination of institutional objectives and organizational structure appropriate to the role of the individual academic medical center in responding to societal and community needs. Not infrequently the work of the institution team at Phase II MAP seminars has focused on specification of medical center objectives and the design of an action plan relative to achieving these objectives.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services; Department of Institutional Development; Department of Teaching Hospitals

AAMC COMMITTEE:

Health Services Advisory Committee
Management Advancement Program Steering Committee

ISSUE: WHAT FACTORS INFLUENCE THE EFFECTIVENESS OF AFFILIATION ARRANGEMENTS BETWEEN MEDICAL SCHOOLS AND TEACHING HOSPITALS?

Increasingly, the non-university owned and/or non-university affiliated (community based) teaching hospital is becoming more involved in providing clinical settings for undergraduate medical education. This appears to be the result of two somewhat parallet developments. First, medical schools in the planning and development stage are choosing to use presently existing community facilities to accomplish specific educational objectives or are finding it increasingly difficult to secure the necessary funding to build and subsequently operate a university-owned hospital facility. Second, established medical schools are increasingly looking toward community based hospital facilities to provide clinical settings whereby class size can be increased and/or a broader clinical exposure can be provided physicians in training.

PRESENT STATE OF POLICY DEVELOPMENT:

Work in the area of affiliation arrangements, sponsored by the AAMC, is as follows: (1) Cecil G. Sheps, et. al., "Medical Schools and Hospitals: Interdependence for Education and Services," (J. Med. Educ., 40: September (Part II), 1965) George Wolf, et. al., "Report of the Second Administrative Institute on Medical School-Teaching Hospital Relations,: (J. Med. Educ., 40: November (Part II), 1965); and (3) Patricia Kendall, "The Relationship Between Medical Educators and Medical Practitioners," (J. Med. Educ., 40: January (Part II) 1965.) At the time this work was completed the number of medical schools and the nature of their relationships with teaching hospitals were relatively stable. Due to the emergence of new (and new types of) medical schools and the development of innovative patterns of clinical experiences constructed by established medical schools, the factors that influence the effectiveness of affiliation arrangements whould be reexamined.

PROGRESS TOWARD ACCOMPLISHMENT:

Planning is underway to establish a joint AAMC-AHA working group that would examine alternative approaches to addressing issues related to affiliation arrangements between medical schools and teaching hospitals. This group would provide general direction for any efforts in this area (investigations, conferences, etc.)

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Teaching Hospitals; Department of Institutional Development

AAMC COMMITTEE:

ISSUE: SHOULD THE AAMC ASSIST THE MEDICAL SCHOOLS IN STRENGTHENING THEIR CAPABILITY FOR DEALING WITH MATTERS THAT ARE CONSIDERED ORGANIZATIONAL MANAGEMENT PROBLEMS?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC responded affirmatively to this issue in 1971 and, with the guidance of representatives of the Council of Deans, set about to identify needs in this area and design specific programs in response. This effort was endorsed by the December, 1972 AAMC Officer's Retreat and the Executive Council.

PROGRESS TOWARD ACCOMPLISHMENT:

Three specific programs have been implemented:

1. The Management Advancement Program

   Executive Development Seminar (Phase I)
   Institutional Development Seminars (Phase II and III)

   Thus far 65 deans have participated in Phase I and 32 schools have attended Phase II. Twenty-three schools have indicated a desire to return for Phase III. The Johnson Foundation grant which supports this program has been renewed for three years.

2. Institutional Studies

   This effort involves the study and analysis of the common body of law and practice in the medical schools relative to institutional organization, governance and management. The delineation of areas being studied is related closely to the kinds of questions asked by the constituency: medical school/center organizational models, analysis of patterns of governance, trends in medical school management are the types of general categories covered. These studies are supported under contract with BHRD.

3. Management Systems Development

   This effort involves an exploration of the "state of the art" of management systems utilization in the medical schools and the means by which the AAMC might enhance management effectiveness through facilitating the development of more refined or appropriate instruments.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Institutional Development, Department of Program Planning and Policy Development.

AAMC COMMITTEE:

Management Advancement Program Steering Committee
Management Systems Development Liaison Committee
Management Program Coordinating Committee

VI. FINANCING OF MEDICAL EDUCATION

ISSUE: HOW SHOULD THE RESPONSIBILITY FOR FINANCING UNDERGRADUATE MEDICAL EDUCATION BE DISTRIBUTED?

Until the 1960's the costs of undergraduate medical education were borne by students through tuition charges, income from endowments and gifts, and state appropriations for publically supported schools. Federal support began in 1963 through student loans and construction grants. This support has been broadened to include scholarships, capitation grants and funds to carry out special projects to improve educational programs and to advance Federal initiatives.

PRESENT STATE OF POLICY DEVELOPMENT:

In the 1950's the Association adopted a policy calling for Federal support to supplement other sources of financing of medical education. Subsequently, the Executive Council has endorsed positions recommended by its committees and task forces calling for multiple sources of support for the costs of medical education from the public and private sectors with a larger and more appropriate share from the Federal government.

In 1970 the Executive Council appointed a Committee on the Financing of Medical Education to make more specific policy recommendations on the responsibility of the public and private sectors and students in meeting the costs of medical education. The Committee has prepared a report, "Undergraduate Medical Education: Elements--Objectives--Costs," which attempts to identify the costs of undergraduate medical education which was approved by the Executive Council in September 1973. The Committee is now developing specific recommendations on the financing of these costs for consideration by the Executive Council.

The recommendations of the Committee on Health Manpower formed the basis for the position adopted by the Executive Council on the extension of the Comprehensive Health Manpower Training Act of 1971.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has promulgated widely its policies on the financing of medical education. Through its activities with the Congressional and Executive branches of the Federal government, it has been involved with the development and enactment of legislation to establish and extend the Federal support of medical education. In testimony before appropriation committees, it has pressed for the funding of legislation authorizing Federal support.

The Association participates in the Federation of Associations of Schools of the Health Professions to promote a unified policy for Federal support of health professions education. It has obtained the support for Association policy positions from a number of other organizations including the American Council on Education, the Association of American Universities, the American Medical Association, and the American Hospital Association.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

Committee on the Financing of Medical Education

ISSUE: HOW SHOULD THE RESPONSIBILITY FOR FINANCING GRADUATE MEDICAL EDUCATION BE DISTRIBUTED?

The principal source of support for graduate medical education has been through reimbursement for health services rendered in the teaching hospital. The training grant programs of the National Institutes of Health have provided support for the preparation of physicians for careers in biomedical research and in the subspecialties. Both the payment of resident stipends from reimbursement for health services and training grants has come under attack. There is not an adequate source of support for graduate medical education in the ambulatory setting which impedes attempts to increase the number of primary care physicians.

PRESENT STATE OF POLICY DEVELOPMENT:

The National Health Insurance Task Force, as a part of their recommendations on Association policy, has stated, "National health insurance is an appropriate mechanism for financing graduate medical education as a means of replenishing the health manpower pool. Graduate medical training includes important elements related to education and delivery of health services as integral parts of the training, and is thus appropriately financed by the health delivery system, both with respect to inpatient and ambulatory care." This report is now being considered by the Executive Council.

The Committee on the Financing of Medical Education is charged with developing a position on financing graduate medical education for consideration by the Councils of the Association. Because of pressures to make recommendations on the financing of undergraduate medical education, it has not yet turned its attention to this issue. The Graduate Medical Education Committee, which has interacted with the Committee on the Financing of Medical Education has informally reviewed and endorsed the recommendations of an ad hoc Committee of the Coordinating Council on Medical Education (CCME) that residency training is a legitimate cost of medical care. When approved by the CCME, the recommendations of the Ad Hoc Committee will be referred to the AAMC for its consideration. The recommendations will be referred to the Committee on the Financing of Medical Education and the Graduate Medical Education Committee for their review and recommendations and with the recommendations of the National Health Insurance Task Force may form the basis of an Association policy position after consideration by the Councils.

PROGRESS TOWARD ACCOMPLISHMENT:

Graduate medical education is now financed primarily through health services income. Unless alternate methods of financing are recommended by the Committees of the AAMC and the CCME and approved by the Councils, the Association will continue to support present arrangements for financing graduate medical education

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

Committee on the Financing of Medical Education
Graduate Medical Education Committee

ISSUE: HOW SHOULD THE DETERMINATION OF THE COST OF MEDICAL EDUCATION BE APPROACHED?

Program cost determination is a valuable tool for self-study. With great care to assure a uniform and satisfactory methodology, it can also be used for interinstitutional comparison. Such studies do have limitations, however, which tend to obscure the interrelationships of programs in the academic medical center.

The Comprehensive Health Manpower Training Act of 1971 (Section 205) required the development of "National uniform standards for determining annual per student educational costs for each health professional school in the future year". The schools may in the future be required to report costs annually as a basis for capitation.

PRESENT STATE OF POLICY DEVELOPMENT:

Since the mid-fifties, the AAMC has assisted the nation's medical schools in the conduct of cost allocation studies, with the objective of providing a mechanism for self-study; uniform guidelines developed by AAMC were employed, but details of the application differed.

The Committee on the Financing of Medical Education was formed in 1970, and the Committee immediately turned its attention to a determination of the cost of medical education. The Committee developed a methodology which recognized that biomedical research and clinical experience are essential components of education, and which took account of resource costs presently financed through voluntary contributions and joint programs with affiliated institutions. The Committee's report was approved by the Executive Council.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC continues to support self-study through program cost finding at the individual medical schools. The Committee's report, "Undergraduate Medical Education: Elements-Objectives-Costs," (J. Med. Educ., 49:97-128, Jan. 74), has been distributed to members of the U.S. Senate and House of Representatives, members of the Administration, and key decision makers at the state level.

The Institute of Medicine has completed a study of the cost of education in all of the professions, with results in broad agreement with the AAMC report. Association staff consulted with IOM staff during the conduct of this study. IOM now has the task of developing a uniform cost determination methodology for future reporting, and the Association has nominated individuals to serve on the IOM Committee overseeing this activity.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development - Division of Operational Studies

AAMC COMMITTEE:

Committee on the Financing of Medical Education

ISSUE: WHAT FEDERAL, STATE AND PRIVATE SOURCES OF FINANCIAL ASSISTANCE SHOULD BE AVAILABLE TO STUDENTS?

Financial aid to medical students is becoming a major issue; rising tuition charges and increases in the cost of living are placing severe demands upon the resources available for financial aid. Coupled with this stress is a developing attitude, particularly in the Federal Government, that the cost of higher education and particularly medical education should principally be borne by the students who ultimately benefit through increased income potential during their working years.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly in 1970 passed an equal opportunity resolution. Contained in this resolution is the recommendation that the Association and the schools design programs to eliminate economic barriers to education in the health professions.

The Association has assumed the position that a principle resource for student financial aid should be the Federal Government provided through the Health Professions Education Act. The Executive Council, at its December 1974 meeting, adopted the recommendations of the ad hoc Committee on Health Manpower, recommending that the 1974 HPEA should provide for an increase in the loan ceiling from $3,500 to $4,500 per student, per year and should authorize appropriations of 75 to 80 million dollars for this purpose. Health professions scholarship ceilings should be increased from $3,500 to $4,500 per student, per year with an entitlement formula providing for sufficient funds so that each institution may meet the needs of low-income students in its classes. It was also recommended that the National Health Service Corp Scholarship Program provide for $6,000 per student, per year and require two years of service in a designated area regardless of the time support was received during undergraduate education.

The Association has no position on the specific obligations of states for the provision of financial aid to medical students.

Various types of loan and scholarship funds from private sources have been studied by committees of the GSA, including the educational opportunity bank concept; but an Association position on a specific program has not been developed.

PROGRESS TOWARD ACCOMPLISHMENT:

The Financial Aid Committee of the Group on Student Affairs and the Committee on Student Information Systems is now expanding the data base regarding the needs for financial aid among medical students. Workshops directed toward improving the management of financial aid offices in the medical schools and increasing the knowledge of financial aid officers regarding sources of funds are being held during the year 1974 in all four regions.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:
Department of Academic Affairs; Division of Student Programs and Services

AAMC COMMITTEE: GSA Financial Problems of Medical Students

VII. MEDICAL SCHOOL ADMISSIONS

ISSUE: SHOULD MEDICAL SCHOOL ADMISSIONS BE ADMINISTERED THROUGH A NATIONAL MATCHING PROGRAM?

The increasing number of applications to medical schools has made it more and more difficult to operate the selection system for medicine in a fashion which provides an optimal opportunity for both the students and institutions to make decisions which are satisfactory to both parties. The successful experience with the National Intern and Resident Matching Plan has led many to suggest that a matching plan for admission to medical school should be instituted.

PRESENT STATE OF POLICY DEVELOPMENT:

On November 3, 1972, the Council of Deans adopted the report of the AAMC Committee on Medical School Admissions Problems together with a recommendation from the COD Administrative Board that "the Association President and appropriate staff explore all aspects of the feasibility of a medical school admissions matching program".

PROGRESS TOWARD ACCOMPLISHMENT:

A technical study, which indicated that matching is theoretically feasible, was completed in March 1973. The medical schools in California and Michigan agreed to participate in a pilot implementation of an admissions matching program, to be conducted with the selection of the 1974-75 entering class. The program is jointly sponsored by AAMC and a grant from the Henry J. Kaiser Family Foundation. In December and January, student rank order lists were mailed to the almost 16,000 individuals who had applied to at least one participating school. In mid-April, participating schools will submit rank order lists of students. The computerized match will be run shortly thereafter, and the results will be compared to the results of the actual admissions process. A report of these results, together with recommendations for further study of admissions matching, will be made to the Administrative Boards and Executive Council in June 1974.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services

AAMC COMMITTEE: Ad Hoc Steering Committee on the Pilot Implementation of a Medical School Admissions Matching Plan

ISSUE: SHOULD SELECTION FACTORS FOR ADMISSION TO MEDICAL SCHOOL INCLUDE CRITERIA OTHER THAN ACADEMIC PERFORMANCE?

Career choice should be understood to embrace such outcomes as area of specialization and practice location. The issue raises something of a dilemma. There has long been public agreement that access to a medical education should be limited to those who are academically qualified. More recently, special opportunities for access to medical education have been afforded to underrepresented minorities. Providing special opportunities to those with personal characteristics which are estimated to influence ultimate career choice and professional performance, adds another dimension to selection decisions and may further modify the established tradition of accepting only the most intellectually qualified.

However, society's demand for greater accessibility to health care may necessitate trials of selection factors related to predicting career choice. A rational decision as to whether to introduce consideration of likely career outcomes in admissions decisions will rest on well documented, empirical evidence demonstrating the reliability of such criteria.

PRESENT STATE OF POLICY DEVELOPMENT:

The selection of students for admission to medical school is and must remain the responsibility of the faculty of each institution. Within this framework, the AAMC assists the institutions in identifying criteria which might influence admissions decisions. In an amicus curiae brief filed in the case of DeFunis v. Odegaard (U.S. Supreme Court, No. 73-235), the AAMC contended that quantitative predictors of academic performance should not be the sole criteria for admission.

The Medical College Admission Assessment Program Task Force and the Group on Student Affairs have addressed this question. Current AAMC activity involved the preparation of the data base necessary for a rational decision. This activity takes the form of an analysis of the MCAT Questionnaire data which includes career choice information and a follow-up of the AAMC Longtudinal Study of the Class of 1960.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association is seeking support for a program to follow-up the Longtudinal Study, correlating measurable characteristics with ultimate career performance. An ad hoc committee has been appointed by the Executive Council to review the recommendations of the MCAAP Task Force and to determine priorities for their implementation.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Educational Measurement and Research; Division of Student Studies

AAMC COMMITTEE: Ad Hoc Longitudinal Study Advisory Committee
Ad Hoc MCAAP Review Committee

ISSUE: WHAT SHOULD BE THE NATIONAL GOAL IN EDUCATING MINORITY STUDENTS IN MEDICINE?

Students from certain minority groups in the United States have been significantly under-represented in medicine. These groups include Black-Americans, Spanish-Americans, American Indians and Puerto Ricans. As a result of the nationwide concerns regarding minority opportunities which developed during the 1960's, major efforts have developed to increase the opportunities for students from these minority groups to study medicine.

PRESENT STATE OF POLICY DEVELOPMENT:

In May of 1970, the Executive Council accepted the AAMC Task Force Report to the Interassociation Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students. In December 1970, the Executive Council approved a policy statement calling for a short-term objective of increasing minority enrollment to 12% by the year 1975-76 in the Nation's medical schools. The policy statement also recommended the development of minority affairs offices in the medical schools and an expanded minority office at the Association. The policy statement recommended that medical school curricula should be modified to adapt to the difference in preparation of minority students in the traditional sciences and that financial constraints for minority students should be minimized.

PROGRESS TOWARD ACCOMPLISHMENT:

The Office of Minority Affairs, which was established at the Association, has published a Medical Minority Applicant Registry (MED-MAR) and "Minority Student Opportunities in U.S. Medical Schools". Both of these publications have been directed toward identifying those minority students seeking medical careers and medical schools seeking students from minority groups. Through an OEO grant, special programs directed toward recruiting and retaining minority students in the health professions were supported in various institutions in the United States.

Workshops directed toward improving selection systems for minority students and assisting schools in meeting the particular cultural and educational needs of minority students have been held in all four regions. A simulated admissions exercise system is being developed for utilization by admissions committees to improve their identification of specific variables pertinent to the selection of minority group applicants.

Minority group enrollment in first-year medical school classes was 4.8% in 1969-70, 7.0% in 1970-71, 8.6% in 1971-72, 8.6% in 1972-73 and 9.2% in 1973-74.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services; Office of Minority Affairs

AAMC COMMITTEE: GSA Committee on Medical Education of Minority Group Students

ISSUE: SHOULD MORE WOMEN BE ENCOURAGED TO ENTER THE MEDICAL PROFESSION?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC has clearly enunciated a policy of no discrimination in admission of students to medical school and in employment on the basis of sex. It has not, however, advanced a policy that more women should be encouraged to enter the medical profession.

PROGRESS TOWARD ACCOMPLISHMENT:

In response to the numerous requests for information about women in medicine from students, faculty, medical school administrators and professional and scientific organizations, the AAMC is attempting to organize data available on this subject. Drawing on the existing and extensive AAMC sources, including Student Information, Faculty Profile Studies, the Longitudinal Study, etc., we have attempted to coordinate the pooling of information pertaining to women in medicine. A special effort has been made to gather information from a wide variety of resources outside the AAMC and to represent the AAMC to the extent possible on an ad hoc basis at meetings and conferences which deal in a significant and relevant way with the subject of women in medicine.

Additionally, the Association will focus on the special problems encountered by women who choose medicine as a career and, for example, has established a Staff Task Force on Affirmative Action to develop means by which the AAMC might assist schools in meeting requirements for affirmative action.

An Office focused on Women in Medicine has been approved in principle and staffed on a collateral duty basis, but has not been formalized organizationally. A project has been outlined which would bring to bear considerable knowledge and expertise about the question posed by this issue. This was being discussed with the Radcliffe Institute as a joint project and planning funds were sought from foundations, but without success. The press of other work has precluded additional effort directed toward raising the funds for the policy development effort or any full time staff.

The enrollment of women in first-year medical school classes was 9.1% in 1969-70, 11.1% in 1970-71, 13.7% in 1971-72, 16.8% in 1972-73, and 19.7% in 1973-74.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Institutional Development

AAMC COMMITTEE:

ISSUE: WHAT IS THE RESPONSIBILITY OF THE AAMC FOR PROVIDING COMPLETE AND ACCURATE INFORMATION TO POTENTIAL APPLICANTS TO MEDICAL SCHOOL?

For both selfish and altruistic reasons, the AAMC should provide increasingly complete and accurate information to potential applicants. Such information should help reduce the wasteful admissions processing caused by the hundreds of thousands of applications per year filed by individuals with no real chance of serious consideration by the U.S. Medical Schools to which they apply. Such information should also help discharge a moral obligation to help reduce the frustration experienced by the tens of thousands of applicants per year who are rejected by all medical schools after spending untold years and dollars preparing for a career which they never had any realistic chance of entering.

PRESENT STATE OF POLICY DEVELOPMENT:

Established by action of the Assembly, 1973. As reported on page 4 of the November, 1973 AAMC Bulletin, the Assembly "approved two OSR-sponsored resolutions calling for the AAMC to gather and disseminate more data on medical school admissions to prospective applicants and premedical advisors." The first resolution asked the AAMC to annually request its member schools to submit information on GPA, MCAT, college majors, sex and minority group composition of students in as recent a freshman class as possible for inclusion in each year's edition of Medical School Admission Requirements (MSAR). It further encouraged schools to submit data on other variables and recommended that GPA and MCAT data be presented in one of a number of "sample standard formats" to be suggested by the AAMC. The second resolution called for the AAMC to encourage and assist undergraduate colleges in providing information to their premedical students regarding the results of applications to medical schools from their preceding classes of premedical students.

PROGRESS TOWARD ACCOMPLISHMENT:

Relative to the first resolution, the AAMC requested much more detailed information from the schools for the 1975-76 edition of MSAR, to be published later this month. For several years, the schools participating in AMCAS have been providing such details in the annually revised "AMCAS Information Booklet." Experimentation is already under way with the "sample standard formats" for GPA and MCAT data and at least one format will probably be included in the 1972-73 Study of Applicants. Concerning the second resolution, the AAMC initiated in 1974 a service for health professions advisors which provides at nominal cost 1) Summary Reports of the Admissions Status for National and Individual Undergraduate School Applicant Pools and 2) Rosters of Applicants from one's Undergraduate School. A related long-range development is the proposed "Career Guidance Booklet" for high school and entering college students which has been recommended by the MCAAP Task Force.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs (Division of Student Studies; Division of Student Programs and Services; Division of Educational Measurement and Research); Division of Publications.

AAMC COMMITTEES:

GSA Committee on Relations with Colleges and Applicants; Ad Hoc Review Committee to Study and Evaluate the Report of the MCAAP Task Force.

ISSUE: DOES THE AAMC OR ITS MEMBER INSTITUTIONS HAVE AN OBLIGATION TO FACILITATE THE CAREER DEVELOPMENT OF U.S. CITIZENS STUDYING MEDICINE ABROAD?

It is estimated that there are between four and six thousand United States citizens studying in medical schools abroad. Most, if not all, of these students have sought medical education abroad with the expectation that they will be able to return to the United States and develop careers as physicians. Many students desire to transfer with advanced standing to U.S. schools. For all students, the opportunity to complete their career development is dependent upon their gaining access to graduate medical education in the U.S.

PRESENT STATE OF POLICY DEVELOPMENT:

In 1969, the Association instituted the Coordinated Transfer Program (COTRANS) to facilitate U.S. citizens in foreign medical schools obtaining information regarding which schools might accept them as transfers at the clinical level and to assist their being admitted to take Part I of the NBME.

In 1972, the Executive Council recommended that the "Fifth Pathway" alternative, developed by the Council on Medical Education of the AMA, not be endorsed and that the medical schools should become more heavily involved in utilizing the COTRANS program to facilitate the transfer of qualified U.S. citizens studying medicine abroad into United States medical schools.

The FMG Task Force report, approved by the Executive Council in March 1974, recommends that the AAMC and interested medical schools sponsor a pilot project to identify and correct educational deficiencies in FMGs, particularly U.S. citizens, and to bring them to a level of professional competence comparable to domestic graduates. This report also recommends that a uniform qualifying examination be administered to all graduates of U.S. and foreign medical schools seeking graduate training in this country.

PROGRESS TOWARD ACCOMPLISHMENT:

Presently, 47 medical schools are listed in the COTRANS program as being interested in accepting U.S. citizens currently in foreign medical schools. There has been an increasing utilization of COTRANS by students in foreign schools: 270 in 1970, 437 in 1971, 676 in 1972, 957 in 1973. However, not all students whose credentials are verified by the COTRANS program and who pass Part I of the National Boards are accepted into United States medical schools as transfer students.

The AAMC is currently seeking foundation support to implement the pilot project mentioned above. As pressures from this large contingent of U.S. citizens mount, medical schools may be asked to develop special undergraduate and graduate programs to facilitate the career development of this group.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs; Division of Student Programs and Services; Division of International Medical Education

AAMC COMMITTEE:

VIII. BIOMEDICAL RESEARCH

ISSUE: WHAT SHOULD BE THE MAGNITUDE OF OUR NATIONAL EFFORTS IN BIOMEDICAL RESEARCH?

The total national health cost rose from approximately $26 billion in 1960 to $83 billion in 1972. During the same interval, federal health expenditures rose ten-fold from $3 billion to almost $30 billion. National expenditures for biomedical research in 1972 were $3.3 billion which contrasts with an expenditure of $0.84 billion in 1960. Two-thirds of our national expenditures for biomedical research and development derive from federal sources, 28% from industry and 8% from other private and public sources.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC policy on this matter is articulated in the document entitled, "A Policy for Biomedical Research," (J. Med. Educ., 46:689-743, Aug. 71). It is recommended that the Nation adopt a policy supporting more, rather than less, biomedical research, in full recognition of the fact that no other course can offer hope for ultimate solutions to health problems. It was further recommended that the national policy for biomedical research assure support at levels sufficient to engage all qualified brainpower and that consideration be given to expansion at a rate determined by widening research opportunities.

The Committee on Biomedical Research and Research Training has recently reviewed this matter and has recommended that 5% of our national health expenditures be earmarked for the support of biomedical research. This is a very low rate of investment for the development of new knowledge and technology for our national health industry which is rooted in scientific and technologic innovation. Most technologically based industries devote more than 5% of their resources to research and development activities.

PROGRESS TOWARD ACCOMPLISHMENT:

The AAMC was instrumental in establishing the Coalition for Health Funding, which represents over 40 organizations concerned that federal health programs are adequately funded. AAMC officers have testified on research appropriations and have encouraged other organizations to support research funding.

In 1973, the Association successfully brought suit forcing the expenditure of Congressionally-appropriated research money which had been impounded by the Executive branch.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

ISSUE: HOW AND BY WHOM SHOULD NATIONAL RESEARCH PRIORITIES BE DETERMINED?

Traditionally, the budget of the NIH and the NIMH had been determined following a dialogue which involved the Executive and Legislative branches of the Federal Government, the public and the various non-profit, voluntary health organizations. The budgets of the NIH and NIMH have been presented to the Congress and the public in such a manner that an interested person or group could evaluate the planned federal expenditures in an area of concern without much difficulty and could then express his interest in changing the allocation of resources to the legislature. Recently, there has been discussion of presenting the budget of the NIH and the NIMH to the Congress as a single line item rather than the usual institute by institute fashion.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association of American Medical Colleges believes that the allocation of resources to our national biomedical research effort and the distribution of these resources should be the subject of a public debate involving both the various branches of the government and the public. Presentation of the budget of the NIH or the NIMH as a single line item would usurp the opportunity for individuals and organizations interested in various aspects of the federal budget to have an opportunity to express their concerns before Congress.

The Association also supports the role of the national advisory councils, which provide both public and scientific input into determining which research programs within an institute deserve priority in funding.

PROGRESS TOWARD ACCOMPLISHMENT:

In testimony before Congress, letters to the Secretary of HEW, and discussion with federal officials, the Association has strongly supported the role of Congress and the advisory councils in determining federal research priorities. The AAMC has urged that appointments to study sections and advisory councils not be influenced by the political affiliation of the nominee.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

ISSUE: HOW AND BY WHOM SHOULD BIOMEDICAL RESEARCH PROPOSALS BE EVALUATED?

External peer review has been a useful tool to guide the investment of research resources into those areas which hold the greatest promise for significant yield from research. Recently, certain individuals within the federal government have questioned whether the external peer review system is a cost-effective management tool. In contrast, the scientific community is convinced that external peer review has been the key element in the success of our national biomedical research program.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has strongly endorsed the principle of external peer review of research proposals. The AAMC believes that external peer review of individual project grants and contracts, as well as requests for proposals, will ensure that our national biomedical research and development resources are allocated to problems of high relevance. External peer review of individual proposals utilizing scientific merit as the primary criterion will ensure that funds are disbursed within the broad policy guidelines established by the legislature.

PROGRESS TOWARD ACCOMPLISHMENT:

The Executive Council of the Association, the Council of Academic Societies Administrative Board and the Committee on Biomedical Research and Research Training have met with various officials of the Department of HEW, the NIH Director's staff, the Director of the Heart and Lung Institute and the Director of the National Cancer Institute to discuss this matter and to offer its concern about the allocation of resources without external peer review.

In testimony before Congress, the Association has endorsed the current NIH and NIMH review system and has urged that appointments to study sections and advisory councils not be influenced by the political affiliation of the nominee.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

ISSUE: WHAT IS THE APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT IN THE SUPPORT OF TRAINING OF BIOMEDICAL RESEARCH SCIENTISTS?

The major health problem for the United States is the continued existence of incapacitating or fatal diseases for which we have neither adequate treatment nor mechanisms for cure. Research in the biomedical sciences offers the only rational approach to this problem. Excellence in research does not automatically follow the flow of funds into a field. It requires the recruitment, training, and cultivation of that relatively small number of individuals capable of working at the frontiers of scientific creativity. The predominant role of the Federal Government in the support of the nation's biomedical research enterprise is well established; it, therefore, follows that the Federal Government should also accept the responsibility for assurance of the quality and quantity of the nation's biomedical research manpower pool.

PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has been actively concerned with ensuring adequate support for the training of biomedical research scientists. Formal policy of the Association on this issue is articulated in the document, "A Policy for Biomedical Research," (J. Med. Educ., 46:689-743, Aug. 71). In this document, it was recommended that the administration and the Congress be urged to continue federal programs providing fellowships and other stipends for advanced training in the health sciences and clinical specialties. More recently, the Committee on Biomedical Research has considered this matter and has recommended: That the Federal Government has the responsibility to support training for research in the biomedical sciences and that the support of such training should be related to the anticipated needs, variety, quality and quantity of qualified biomedical scientists. To achieve this goal, the Committee recommends that a more formal mechanism be established to examine, on an on-going basis, both the supply and demand for biomedical scientific manpower by discipline category, with the recognition of the long-lag phase between entry into the training pipeline and the emergence of an independently competent investigator.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has testified in support of training legislation, both in the House and Senate, and has worked actively toward ensuring the continuation of both federal and nonfederal support of training of biomedical research scientists. In October, 1973 the Association sponsored a research manpower workshop in Seattle, Washington and will publish the proceedings of this workshop in the Spring of 1974.

The Association in 1973 successfully brought suit to force the expenditure of Congressionally-appropriated research training funds which had been impounded by the Executive Branch.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

ISSUE: WHO IS RESPONSIBLE FOR ENSURING THAT THE RIGHTS OF THE SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH ARE PROTECTED?

There is increasing public concern regarding the protection of human subjects in biomedical research. A bill to establish national standards for biomedical research involving human subjects is before the Congress and attempts have been made to introduce amendments to this legislation which would prohibit research on fetuses, infants and children. The DHEW is also in the process of modifying its guidelines for biomedical research involving human subjects and is in the process of adding new regulations pertaining to institutionalized subjects with limited ability to provide informed consent.

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC policy on this issue is predicated on the fact that biomedical research involving human subjects is an essential component of the process whereby new and innovative ideas are evaluated before being made available to the public as accepted modalities of health care. The Executive Council approved a policy statement in September 1972 asserting that academic medical centers have the responsibility for ensuring that all biomedical investigations conducted under their sponsorship involving human subjects are moral, ethical, and legal. The centers must have rigorous and effective procedures for reviewing prospectively all investigations involving human subjects based on the DHEW Guidelines for the Protection of Human Subjects as amended December 1, 1971. Those faculty members charged with this responsibility should be assisted by lay individuals with special concern for these matters. Ensuring respect for human rights and dignity is integral to the educational responsibility of the institutions and their faculties.

PROGRESS TOWARD ACCOMPLISHMENT:

The Association has actively supported legislation directed toward the establishment of national standards for the ethical aspects of biomedical research and has participated in the revision of the Department of Health, Education and Welfare Guidelines which pertain to the Protection of Human Subjects participating in biomedical research in situations in which there are limitations on the ability of the subject to give informed consent, i.e. the child, the institutionalized mentally disabled and the prisoner.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs/Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

ISSUE: WHERE SHOULD OUR NATIONAL BIOMEDICAL RESEARCH PROGRAMS BE CONDUCTED?

During the past eight years there has been a trend toward conducting a greater portion of our federally supported biomedical research programs in for-profit institutions and a decreasing portion in non-profit institutions, such as academic medical centers.

PRESENT STATE OF POLICY DEVELOPMENT:

The Committee on Biomedical Research and Research Training has considered this matter and has emphasized that there are finite benefits to be gained from conducting biomedical research in the same institutions in which both medical education occurs and health care is delivered. For example, scholarly activities such as biomedical research conducted by medical school faculty expose medical students to the development of new knowledge and stimulate their desire to keep abreast of new developments which will influence their later practice of medicine. Conduct of biomedical research programs in the environment in which health care is delivered stimulates the rapid transfer of innovative new ideas to the delivery of routine medical care. Thus, the Committee recommends that sponsors of biomedical research programs take maximum advantage of this unique opportunity to improve national health.

PROGRESS TOWARD ACCOMPLISHMENT:

In testimony presented to Congress on the National Cancer Act, the National Heart and Lung Act, and before both the House and Senate appropriations committees, the Association has emphasized the important role of academic medical centers in the conduct of our national biomedical research programs.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Academic Affairs, Division of Biomedical Research

AAMC COMMITTEE:

Committee on Biomedical Research and Research Training

IX. HEALTH CARE

ISSUE: IS THERE A SHORTAGE OF PHYSICIANS IN THE UNITED STATES?

No study has ever concluded to the satisfaction of all what the number of physicians in the U.S. should be. Geographic and specialty maldistribution cause shortages and surpluses to exist simultaneously. It has been politically popular to call for more doctors without concurrent efforts to direct them to shortage areas. It has been politically untenable to say there are enough physicians without proposing some means of redistribution.

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC policy holds that any determination of the number of physicians needed must take into account the complex problems of physician distribution. The view of the 1970 Howard Committee report approved by the Assembly, (See - J. Med. Educ., 46:105-116, Feb. 71) that physician shortages would be met by a medical school enrollment increase to 15,000 entering students by 1975-76 is supported. This increase would give the U.S. one of the highest physician/population ratios in the world by the mid-1980's.

The impact of the recent expansion of medical school class size on the health care system should be observed and measured before the need for more physicians can be assessed.

PROGRESS TOWARD ACCOMPLISHMENT:

The goal of enrolling an entering class of 15,000 medical students by 1975-76 will most likely be met. The Association has supported programs designed to alleviate shortages by encouraging physicians to enter primary care or to practice in shortage areas. In discussions with the Congress and the Executive Branch of the Federal government, the Association has recommended that the impact of the current medical school class size on the health care system be evaluated before further expansion is required.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

ISSUE: WHAT SHOULD THE AAMC AND ITS MEMBER INSTITUTIONS DO TO REMEDY THE MALDISTRIBUTION OF PHYSICIANS AMONG SPECIALTIES?

There is a growing consensus that the pattern of specialization among physicians is inconsistent with the health care needs of the Nation. Although the precise forecasting of the numbers and types of specialists which will be needed in the future is inexact, presently conventional wisdom concludes that considerably more generalists-specialists are needed and considerably fewer more narrow specialists are needed.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association adopted as its major emphasis during 1973 the improvement of education for primary care specialists. The Graduate Medical Education Committee has recommended that 50% of graduating medical students should become primary care specialists.

An ad hoc committee of the Coordinating Council on Medical Education is studying the problem of specialty maldistribution. The report of that committee, when approved by the CCME, will be forwarded to the Association for approval.

The AAMC Executive Council approved a proposal for the renewal of health manpower legislation which would provide the incentive of additional capitation support to schools undertaking primary care education initiatives.

PROGRESS TOWARD ACCOMPLISHMENT:

In the Fall of 1974, the Association will sponsor an Institute on Primary Care. Through its position on institutional responsibility for graduate medical education, the Association has urged the academic medical centers to develop decision-making processes regarding the numbers and types of residency and fellowship programs they sponsor. The Association is cooperating with specialty groups seeking to determine the numbers of specialists being trained and projecting these numbers against predictions of future needs. Current negotiations are underway with the AMA to develop a feedback system to the schools so that they will be informed regarding the selections their students make for specialty training and ultimate career development.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development; Division of Operational Studies
Department of Health Service; Department of Academic Affairs

AAMC COMMITTEE:

CCME
Graduate Medical Education Committee
Task Force on Primary Care

ISSUE: WHAT SHOULD THE AAMC AND ITS MEMBER INSTITUTIONS DO TO REMEDY THE MALDISTRIBUTION OF PHYSICIANS AMONG GEOGRAPHIC AREAS?

Geographic maldistribution of physicians is a major public concern. There are complex interrelated reasons why physicians choose one particular societal and geographic setting over another in which to establish themselves. Generally, physicians are attracted to affluent communities which provide recreational and cultural opportunities compatible with their educational background and experience. Short-term solutions for providing physician services to both metropolitan and rural areas in need of these services have been provided through the National Health Services Corps. The NHSC depends upon financial incentives, based upon loan forgiveness, to enroll students for two-year periods of assigned services.

PRESENT STATE OF POLICY DEVELOPMENT:

The Association supported the establishment of the NHSC in 1971; and the Committee on Health Manpower for 1974 recommended that the grant-in-aid provided for NHSC enrollees be increased from $4,000 to $6,000, and that the period of service be no more than two years without regard to the number of years' support students received during their undergraduate education. The Committee also recommended special incentives to institutions for the establishment of educational experiences in shortage areas.

PROGRESS TOWARD ACCOMPLISHMENT:

Promoting the provision of student experiences in areas of chronic physician shortage (rural and urban inner city) has not been specifically planned. Several schools have been engaged with the development of area health education centers or variances on this concept for both undergraduate and graduate students. Regionalizing medical education in this manner cannot effectively be accomplished without special financial resources. Initially, these resources must be derived from foundations, states or the Federal Government. Long-range plans for sustaining regionalized programs are essential.

The Association has supported legislation which would provide resources to enable academic medical centers to provide education and care in shortage areas. In testimony before Congress on Area Health Education Centers and similar proposals, the AAMC has emphasized the need for educational support so that students may be trained in more diversified geographic settings.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Planning and Policy Development/Division of Operational Studies

AAMC COMMITTEE:

ISSUE: SHOULD ACADEMIC MEDICAL CENTERS ASSUME RESPONSIBILITY FOR DEVELOPING NEW MODES OF PROVIDING HEALTH CARE?

In the midst of the debate over national health insurance and the various approaches to improving the financing and delivery of health services, the HMO and the restructured outpatient department have emerged as possible alternative approaches toward improving health care. The problem of inefficiency of operation and inadequacy of services in the traditional OPD are well known. The university-operated OPD in particular, suffers from inadequate funding, inefficient organization, rising costs and increased workloads.

PRESENT STATE OF POLICY DEVELOPMENT:

This issue must be addressed by each constituent institution, taking into account local needs, resources and interests. Because of their unique resources, academic medical centers bring to the development of health care services the full spectrum of medical, social and behavioral sciences. The experiments of those institutions in HMO development and operation, as well as OPD restructuring could well serve as models for other academic medical centers that anticipate adopting these approaches to health care delivery.

Past AAMC testimony on health maintenance organizations has supported the request of funds for the development of academic medical center related HMOs.

PROGRESS TOWARD ACCOMPLISHMENT:

In 1972 the Department of Health Services contracted with the HMO office of HEW to assist in the development of prototype HMOs affiliated with academic medical centers. The five institutions selected to participate have received consultative support and technical assistance to develop their HMO models. Although the project will terminate in June, 1974, the participating institutions may apply for direct federal assistance for further planning, development and operational support.

The Department of Health Services is submitting a proposal for support of a project to strengthen and upgrade university outpatient departments. The project's major emphasis will be on restructuring OPD activities into a strong academic base for primary care and on facilitating their integration with the overall institutional program. If funds are obtained, the Departmental staff will provide technical assistance and consultation to AAMC institutional members that are interested in OPD reorganization.

The prototype HMO project has made it possible for five selected academic medical centers to receive support and assistance in addressing the various critical issues attendant to the development of an HMO. After termination of the project, the Association will prepare a final report and a list of consultants to be made available to all interested constituent institutions.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE:

Health Services Advisory Committee

ISSUE: WHAT IS THE ROLE OF THE MEDICAL SCHOOLS AND TEACHING HOSPITALS IN TEACHING HEALTH PROFESSIONALS TO WORK AS A TEAM, BETTER RELATING RESPONSIBILITY TO TRAINING?

The immediate demand for primary medical services coupled with the current geographic and specialty maldistribution of physician manpower requires alternate approaches to the health manpower shortage. Training programs for new health care practitioners such as physicians' assistants and nurse practitioners have developed partially in response to this need. In order to function effectively as a team, the new health professionals and physicians should be trained together in clinical settings which focus on their collective roles and responsibilities as a provider unit. Such joint interdisciplinary training has the potential for increasing the supply and effectiveness of primary care personnel for both urban and rural populations.

PRESENT STATE OF POLICY DEVELOPMENT:

Although this is an institutional responsibility dependent upon local needs and resources, the AAMC strongly encourages constituent efforts in seeking programmatic support for these activities.

It is felt that the academic medical centers might take an active role in developing common core curriculum for medical students and new health practitioners which reflect a team approach to the delivery of primary health services. However, there is need for experimentation in the clinical environment to evaluate the validity of the team concept, of various approaches to organization and structure, and of the most effective means to integrate this concept into clinical education.

The Association's Health Manpower Legislation proposal, as approved by the Executive Council, supports interdisciplinary training through capitation incentives.

PROGRESS TOWARD ACCOMPLISHMENT:

An AAMC survey in 1973 identified 69 academic medical centers currently involved in educational programs for new health practitioners. One-third of these programs have students attending didactic courses with medical students and two-thirds training medical students and health practitioner students together in clinical settings.

Beginning May 1, 1974, the Department of Health Services will contract with BHRD to develop pilot physician training programs in HMOs, one component of which will explore the integration of training programs for physicians and new health practitioners. A proposal was also submitted to BHRD in March, 1974, which outlined a two-and-a-half year project to assist academic medical centers in developing, implementing and evaluating primary care training programs at both the graduate and undergraduate level. The project will involve 4-6 constituent institutions and will focus on several activities including the development of core curricula for teaching the team concept of delivering health services.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE:

Health Services Advisory Committee

ISSUE: SHOULD ALL AMERICANS BE GUARANTEED THE ABILITY TO PAY FOR NECESSARY MEDICAL CARE?

Because national health insurance is a high priority legislative issue with the Congress, the AAMC will increasingly be called upon to express its views regarding regarding the scope of benefits and co-insurance and deductible features of any national health insurance program which may be proposed.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly adopted a policy on national health care in February 1971 which included the statement, "The Association of American Medical Colleges supports the concept that adequate health care and maintenance is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system. This system must be a national one, with adequate provision for varying regional requirements."

A more explicit Association policy is being developed by the Task Force on National Health Insurance and by the Executive Council. The report of the Task Force says: "A program of national health insurance is designed to provide ready financial access to the health care system and to shift the financial burden of health care from personal expenditures to insurance coverage, thus broadening the financial base available to support health care costs. Ideally, there should be no cost-sharing under a national health insurance program. If there is cost-sharing through deductibles, co-insurance or co-payment, they should be set at minimum levels. They should not be burdensome in the aggregate; they should be waived for low income persons; they should only be high enough to avoid over-utilization. The cost-sharing should not be applicable to essential minimum services, and the cost of administering the cost-sharing program should not exceed savings from avoided over-utilization."

The report of the Task Force has been submitted to the Executive Council for review and comment.

PROGRESS TOWARD ACCOMPLISHMENT:

A recommended Association policy is currently under review by the Executive Council. The policy will form the basis of testimony before committees of the Congress considering national health insurance.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Federal Liaison; Department of Teaching Hospitals; Department of Health Services

AAMC COMMITTEE:

Task Force on National Health Insurance

ISSUE: SHOULD THE METHOD OF FINANCING MEDICAL CARE DETERMINE THE ORGANIZATION OF THE DELIVERY SYSTEM?

Inherent in any debate on national health insurance is the extent to which the method of financing should be used as a mechanism to influence the organization of medical services. In the context of the overall policy question are such issues as the distribution of personnel and facilities, quality assurance as well as the nature and scope of regulatory bodies to monitor the sytem.

PRESENT STATE OF POLICY DEVELOPMENT:

The Assembly adopted a policy on national health care in February 1971 which included the statement, "The Association of American Medical Colleges supports the concept that adequate health care and maintenance is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system."

A more explicit Association policy is being developed by the Task Force on National Health Insurance and by the Executive Council. The report of the Task Force says, "Although national health insurance per se may not effect a drastic restructuring of the health care delivery system, it should promote needed changes. To define and then bring about the ideal delivery system is too great a task to be accomplished in a single step. A major purpose of national health insurance legislation is to create a better means of financing medical care. National health insurance also should both permit and strongly encourage changes in the present delivery system."

The report of the Task Force has been submitted to the Executive Council for review and comment.

PROGRESS TOWARD ACCOMPLISHMENT:

A recommended Association policy is currently under review by the Executive Council. The policy will form the basis of testimony before committees of the Congress considering national health insurance.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Division of Federal Liaison; Department of Teaching Hospitals; Department of Health Services

AAMC COMMITTEE:

Task Force on National Health Insurance

ISSUE: WHAT IS THE RESPONSIBILITY OF ACADEMIC MEDICINE IN ADVANCING THE STATE OF THE ART OF QUALITY OF CARE ASSESSMENT?

The recent PSRO legislation serves as a hallmark of the trend toward provider responsibility in assuring the quality of patient care. The issue of quality is one that is closely related to access. Above and beyond the availability of health services, there is the need to assess objectively the level and quality of care that is provided.

PRESENT STATE OF POLICY DEVELOPMENT:

In March 1973, the Executive Council approved 5 propositions directed toward a new thrust in continuing education. The second of these propositions was, "Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm."

The AAMC believes that the academic medical center is in a unique position to undertake the tasks of developing feasible quality assessment tools, criteria and standards of measurement, and of implementing quality assurance mechanisms.

PROGRESS TOWARD ACCOMPLISHMENT:

The Departmental staff is now in the process of exploring with DHEW the possibility of a collaborative project with a selected number of academic medical centers in order to test and validate various approaches to the development of medical care criteria and outcome assessment. This is projected as a one- to two-year study to be coordinated through the Department of Health Services.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Health Services

AAMC COMMITTEE:

Health Services Advisory Committee/Subcommittee on Quality of Care

ISSUE: HOW SHOULD ABSOLUTE HOSPITAL COSTS AND THE RATE OF HOSPITAL COST INCREASE BE CONTROLLED?

Proposed regulations regarding Section 223 of P.L. 92-603 and adopted rules implementing Phase IV of the Economic Stabilization Program have established limitations on both absolute hospital costs and the rate of hospital cost increase. As proposed routine service cost will be limited on an average per diem basis depending upon the hospitals geographic location, (metropolitan, non-metropolitan), the per capita income of the state in which it is located and its size. The rate of hospital cost increase is presently regulated on a per admission basis (7.5 percent per year allowable increase); certain pass-throughs, adjustments and exceptions are provided for.

PRESENT STATE OF POLICY DEVELOPMENT:

Developed in Association's formal comments on Phase IV proposed rules (dated November 30, 1973) and comments on Section 223, P.L. 92-603 draft regulations (dated November 21, 1973).

The Association has held that proposed regulations regarding Section 223 of P.L. 92-603 and Phase IV Health Care Rules do not adequately take into consideration special features of the cost structures of teaching-tertiary care facilities. Section 223 proposed regulations seek to implement controls which do not take into account variations in patient mix and the nature and scope of services provided by hospitals. Phase IV rules do not allow for the fact that cost experiences a higher rate of increase in teaching-tertiary care hospitals as a result of the research and development activities engaged in by such facilities. In combination these regulations subject hospitals to two different control mechanisms, one controls absolute costs on a per day basis, the other controls the rate of increase by stay; when implemented together these mechanisms are incompatable.

PROGRESS TOWARD ACCOMPLISHMENT:

An ad hoc committee on the economic controls of the Council of Teaching Hospitals, chaired by Sidney Lewine has been formed to address both absolute and rate of cost increase issues. Based upon suggestions of the Association (and others) Phase IV proposed rules were significantly modified to allow for adjustment in the changes in cost and charges due to alterations in case mix. The Association has prepared an analysis of the Economic Stabilization Program as it influences hospitals -- this analysis has been forwarded to the Senate Banking and Currency Committee. It now appears that the Economic Stabilization Program will not be extended. Work is now underway to analyze data upon which the method for limiting absolute cost under Section 223 was established. Association comments on these regulations have been filed.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED:

Department of Teaching Hospitals

AAMC COMMITTEE:

Ad Hoc Committee on Economic Controls