AGENDA

of the

ORGANIZATION OF STUDENT REPRESENTATIVES

February 3, 1972
1:30 pm - 5:00 pm
Room PDR 14

February 4, 1972
1:30 pm - 5:00 pm
Chicago Room

Palmer House
Chicago, Illinois

February 4, 1972
4:15 pm - 5:15 pm
Monroe Ballroom

Meeting with the Council of Deans

I. MINUTES OF THE PREVIOUS MEETING

ORGANIZATION OF STUDENT REPRESENTATIVES

The first meeting of the OSR opened with an address by Mr. Larry Holly, National Secretary of the Organization of Student Representatives Planning Committee, which introduced the student delegates to the background of the OSR. This was followed by a welcome and brief historical sketch of the AAMC by its Chairman, Dr. William Anlyan. The proposed rules and regulations of the OSR were discussed, amended and adopted by a unanimous vote of the Organization. (Copy attached) The Council of Deans approved the document at its meeting on the following day. Election of officers then took place with the following results:

Chairman - Larry Holly, University of Texas at San Antonio

Chairman-elect - Kevin Soden, University of Florida, Gainesville

Secretary - Steven Ketchel, University of Arizona

Regional Representatives:

Southern Region - Harold Stewart, University of Oklahoma
Western Region - Allen Richardson, University of California, Los Angeles
Central Region - Sol Edelstein, Wayne State University
Northeast Region - Geraldine Richter, Georgetown University

Other Representatives to the AAMC Assembly:

Monty Hughes - University of Southern California
Larry Wellikson - Temple University

The first business meeting under the stewardship of the new officers was held the following evening when committees of the Organization of Student Representatives were formed. These included committees on Finance, Rules and Regulations, Liaison with External Student Organizations, Political Action, Nominations, Senior Electives and Minority Affairs. Chairmen of these committees have been appointed and they will soon be working toward developing policies in their respective areas for action by the OSR at its next meeting.

The organization then heard an address by Dr. Donald Wharton, presently a member of Ralph Nader's Task Force on Health Affairs,

who communicated his concerns in the field of health care.

The Organization went on to approve two resolutions that evening. One requested that the National Intern and Resident Matching Program retain the option for married students to match together under the program. Second, a resolution was sent to the Assembly of the AAMC requesting that steps be taken by the Executive Council of the AAMC to explore all possible steps toward accomplishing the goal of active participation of schools of osteopathic medicine in the Association. This resolution was considered before the Assembly at its session and tabled at that time.

11/22/71

II. CHAIRMAN'S REPORT

Three months have passed since the last meeting of the OSR. This has been a hectic time in the life of the OSR. Establishing appropriate channels for correspondence, putting together resource material as well as a report of the October meeting, planning for the February meeting -- all these things have occupied a great deal of time. However, none of this could have been accomplished without the willing and effective assistance of the AAMC staff, particularly Dr. Roy Jarecky and Mr. Joe Keyes.

The Airlie House Retreat was held in early December which your Chairman attended. Priorities of the Association were discussed. You will find these outlined elsewhere in this agenda.* The nature of faculty representation was discussed and the conclusions are also outlined here. The possibility of housestaff representation was discussed.

The COD Administrative Board held its meeting the day before the Executive Council meeting in Washington, D.C. Your Chairman's report to the COD's Chairman was discussed, as was the possibility of a joint meeting of the COD and the OSR.

The Executive Council met on December 17. Many of the items discussed at that meeting appear in our agenda.

This meeting is going to be very important in the life of the OSR. We need to complete the task begun in Washington and to move from there.

Larry Holly

*Attachment I

1/19/72

FOR DISCUSSION:

ATTACHMENT I

AAMC PRIORITIES FOR THE FUTURE

Federal Program

1. National Health Insurance
2. Educational Support
3. Appropriations (education, research, delivery)
4. Miscellaneous

Association Reorganization

1. Faculty -- House Staff
2. Institutional Representation
3. Affiliated Organizations

Financing of Medical Education

1. AAMC study
2. Institute of Medicine study

Educational Push

1. Graduate Medical Education
2. Accreditation
3. Use of New Technology

Management of the Academic Health Center

1. Management Skills
2. Management Information Systems
3. Consultation

III. COMMITTEE REPORTS

The following are reports from the Senior Electives Committee and the Finance Committee.

15 December 1971

Dear Senior Electives Committee Member:

Enclosed is a sample of what ideas I have had about a survey for the catalogue OSR eventually hopes to put out. As you probably already know, there is little in the way of communication between medical schools about the various electives each offers, which usually winds up with a few informed students arranging interesting elective schedules and the rest left in the lurch.

This catalogue is an attempt to let all students know where they can apply, for what, for how long, etc., without writing numerous unnecessary letters to each department chairman as a preliminary. It also attempts to inform students of the relative size and patient load of the department so that each student can select an elective tailored to his own needs.

My idea is to send some letters and questionaire forms to each school so that each OSRepresentative can distribute them to the various departments in his school, collect them, talley them on one sheet, and return them to a member of the committee. Then when the schools return the forms, we can begin to compile a catalogue for distribution to the various medical schools, in hopes that each medical student will have access to this information -- not just a priviledged few.

Please look over the form and the letter and send your suggestions to me as soon as you can. This is by no means complete and I depend on all of you to help me with your comments, suggestions and revisions so that this idea can have practical value.

Sincerely,

Barb

Barbara S. Costin
Chairman, Senior Electives
Committee

Enclosures (2)

Return suggestions to: Barbara S. Costin
Box 191
Medical College of Pennsylvania
3300 Henry Avenue
Philadelphia, Pennsylvania 19129

Dear Department Chairman,

The American Association of Medical Colleges, Organization of Student Representatives has formed a committee for the purpose of gathering and disseminating information to medical students concerning the availability of elective clinical rotations at other schools. To this end the committee is attempting to catalogue all the electives offered at all the participating schools.

The questions on the enclosed survey will serve to alert students to the possibilities available in the various departments, such as

Question #1 - asks whether the department would simply consider an application for the elective. It by no means assures the student who applies automatic acceptance simply by listing of availability. Please indicate with a check if the answer is yes.

Question #2 - asks for the number of weeks the elective carries. The numerator asks for the least number of weeks a student may have on the elective to be of instructive benefit. The denominator asks for the maximum number of weeks a student may spend on the elective. For example, 4/12 indicates a minimum number of four weeks and a maximum number of 12 weeks.

Question #3 - asks whether a student must have senior status (who has finished the basic junior rotations of medicine, surgery and ob-gyn/peds.). Or may the student take the elective at some other time in his medical school training? Please indicate by SS if the former is the case, and O, if other than this is feasible.

Question #4 - asks whether the school or hospital may offer assistance such as student apartments, room in the hospital or free meals, or a stipend for the rotation. Please indicate with "R" if free room is provided, "M" if free meals are provided at any time, or "$" if any stipend may be applied for or provided. Leave space blank if none of these are provided.

Question #5 - asks the number of staff in each category, to help the student ascertain the size of the patient loan anticipated in the rotation, as well as a rough estimate of the teaching opportunities to which the student may be exposed. Since different students have different needs as to supervision and patient load wanted on different rotations, this question is not meant in any way to judge a department merely on its size.

Question #6 - asks the times the elective is offered so that the school's own students may be accommodated during the heavy load times of the year, yet available places during a lighter period may accommodate students from other schools.

Thank you for your cooperation in our project. The information will help us set up the catalogue that every medical student may eventually have access to.

Please return the completed questionaire as soon as possible. If you have any questions concerning its content, please let me know.

Sincerely,

, Senior Electives
Committee Representative

Departments	Dept. would consider application of a student from another school for elective	Minimum/Maximum # weeks to be spent on elective.	Prerequisite req? Must student have senior status (post all junior rotations	Is any financial assistance, grant, room, board offered?	Number of residents/ interns/ attendings on this service.	What times of year is elective offered?	Earliest/Latest Date to apply.	Person in Dept. to address applic. to
1. Medicine								
2. Endocrinology								
3. Renology								
4. Gastroenterology								
5. Cardiology								
6. Neurology								
7. Medical ICU								
8. Emergency Room (Acute Care)								
9. Hematology								
10. Clinical Pathology								
11. General Surgery								
12. Neurosurgery								
13. Plastic Surgery								
14. Oncology								
15. Orthopedic Surgery								
16. Pediatric Surgery								
17. Urology								
18. Pathology								
19. Pediatrics								
20. Anesthesiology								
21. Psychiatry								
22. Obstetrics								
23. Diagnostic Radiology								
24. Therapeutic Radiology								
25. Gynecology								
26. Family-Community Medicine								
27.								
28.								
29.								
30.								
31.								
32.								
33.								
34.								
35.								

22 December, 1971

To Members of the Finance Committee:

At our first meeting prior to leaving Washington we discussed the financial requirements of the OSR and the avenues we might explore to fulfill these needs. I have classified our financial needs in the following manner:

1. Financing at the national level
   Included in this category are costs for:
   - national meetings
   - national correspondence
   - meetings which officers of the OSR may have to attend
   - additional staff that the AAMC may require to handle OSR business

2. Financing at the regional level
   Included are costs for:
   - regional meetings
   - regional correspondence

3. Financing of programs initiated by the OSR

Enclosed with this report is a copy of the guidelines for the OSR adopted by the Council of Deans and the Executive Council of the AAMC. The paragraph on Finances on page three is pertinent to this report. (Attachment I)

Items one and two of the adopted guidelines indicate that the AAMC will provide funds necessary for OSR officer attendance at meetings and for additional staffing requirements.

Item three delegates to each individual institution the responsibility for providing funds for its representative to the OSR. This includes costs associated with attendance at national and regional meetings. The financial responsibility each institution bears to the OSR is the same it bears to its delegates to the Council of Deans and the Group on Student Affairs. Any representative encountering difficulty in obtaining funds to attend the February meeting should contact Larry Holly.

Funds necessary for programs initiated by the OSR are generated internally through the AAMC staff. Funds are provided either through existing budget allocations or by obtaining new grants or contracts from the Federal government. If a grant proposal is necessary it is prepared by the AAMC staff at the request of the OSR. The technicalities of writing a grant proposal are handled by the staff and are not a direct concern of the OSR.

Costs for regional correspondence will be assumed by the AAMC if material is sent to the staff in Washington for duplication and distribution.

The mechanisms assuring the financial viability of the OSR have been elucidated and I feel that the task assigned to the Finance Committee has been completed. Future duties of the Committee will have to be determined at the February meeting.

Respectfully submitted,

(Signed)
Richard O'Connor
Chairman
Finance Committee

The Chairman of the COD will nominate student members to appropriate committees of the Association upon receipt of the recommendations of the OSR.

RULES AND REGULATIONS

The OSR shall draw up a set of Rules and Regulations, consistent with these guidelines and the Bylaws of the AAMC, governing its internal organization and procedures. The Rules and Regulations shall be consonant with the goals and objectives of the COD.

The initial meeting of the OSR shall be organized by the Committee chosen at the October, 1970, meeting of the Association to carry forward the formation of the OSR and shall be chaired by the Chairman of that group.

FINANCES

At its May 20 meeting, the COD voted to recommend to the Executive Council that the finances of the OSR be handled in the following manner:

- The Association will meet the cost of the travel required for authorized student participation in Association committee activities, i.e., Executive Council, Administrative Board, and designated committee meetings.
- Staffing expenses will be allocated by the President by administrative action.
- Other costs associated with student participation will be individually arranged at the institutional level.
- The participating institutions shall incur no additional institutional assessment to the Association upon the initiation of this proposal. Expenses incurred by the Association in support of this organization will be met within currently budgeted funds or from appropriate external sources.

V. RELATIONSHIP OF THE AAMC TO RELATED HEALTH ORGANIZATIONS

One of the chief concerns of students attending the initial meeting of the Organization of Student Representatives was the relationship of both the student organization and the Association to the related and allied health professions and their organizations. This concern was a recurrent theme in many of the campaign speeches of candidates seeking election to OSR offices and subsequently found expression in a resolution forwarded to the Assembly. The students, acutely aware of the complexities of health care delivery in modern settings, perceived a pressing urgency to engage in joint considerations of problems of health education and health care delivery with their colleagues in these related professions. Dismayed that only medical students were eligible to become voting members of the OSR, some voiced the opinion that such a restriction should soon be eliminated, or alternatively that an appropriate accommodation be made to provide for the active participation of other categories of health professions students in the AAMC.

This general concern found more specific expression in a resolution passed at the second meeting of the OSR which was forwarded through the Resolutions Committee to the Assembly (text of resolution attached - Attachment I). This resolution envisioned, as an appropriate first step, the increased involvement of students and schools of osteopathic medicine in the affairs of the AAMC. The Assembly tabled the resolution pending an exploration of the issues involved in such a course. The purpose of this paper is to trace certain historical developments relevant to the consideration of the appropriate relationship of the AAMC to schools of osteopathic medicine and other health professions organizations.

The Coggeshall Report

The ecumenical spirit reflected in the students' approach to the appropriate make-up of the AAMC was foreshadowed in the Coggeshall Report, submitted to the Executive Council of the AAMC in April 1965.

> *"Organization of the association should be concerned with the improvement of health in all its aspects, particularly in the comprehensive function of education for health and medical sciences and also in improved care, treatment, research, and other aspects. It should evidence authentic consideration of broad national and public interests and those of universities.*
>
> *Representation in the association should include all principal elements of the university community involved with education for health and medical sciences. Provision should also be made for participation of other related organizations, expression of their views, and effective working relationships with and among them. It*

should be mainly an association of institutions and organizations, but both formal and practical provisions should be made for active involvement of responsible and concerned individuals."

The Report therefore recommended for the Executive Council's consideration two new mechanisms of participation.

"(4) AFFILIATE MEMBERS

Also within the association's framework of organization, it is recommended that provision be made for suitable participation of other organizations concerned with health and medical sciences. Recognizing that there is a broad range of interest among organizations, and varying types of organizations, two different types of relationships should be provided. The difference between them should be identified by the nature and purpose of the organizations involved and by the mutual preference of the relating organization and the association.

The first of these relationships should provide for "affiliate members." Organizations directly and responsibly involved in education for health and medical sciences should be encouraged to become directly affiliated with the association. For this purpose, it is recommended that a third class of membership be created, by which such organizations could become affiliate members upon application. Affiliate members should be entitled to representation in the over-all governing body but should not otherwise have decisive voice in affairs of the association. Affiliate members should come largely from among the teaching hospitals and the organizations of teachers and researchers of various scientific and clinical subjects.

(5) RELATED ORGANIZATIONS

In addition to actual members, it is recommended that the association recognize as "related organizations" other organizations primarily concerned with education or practice in health and medical sciences. Formal continuing working relations should be established with related organizations, and specific organizational arrangements should be made for their involvement in affairs of the association. Working relations should include such activities as exchange of information and publications, participation in meetings and activities,

joint studies and experimental or demonstration projects, and limited participation in policy and program considerations of the respective organizations.

The related organizations should be expected to include those (such as the American Medical Association) with which the association has already established cooperative contact, plus other professional or institutional associations, the various professional organizations by medical specialty, voluntary citizen organizations in the health field, and others with common interests."

In a subsequent reorganization the AAMC has made provision for participation of those which the Report recommended as affiliate members "largely from among the teaching hospitals and organizations of teachers and researchers of various scientific and clinical subjects" through the establishment of its Councils of Teaching Hospitals and of Academic Societies.

Subsequent discussions relating to the formal recognition of "related organizations" by the AAMC stimulated the response by those concerned that they considered it highly inappropriate to be so named or related to the formal organizational structure of the AAMC. Other mechanisms have been sought to achieve the goals enunciated by the Coggeshall Report.

The Federation of Associations of Schools of the Health Professions

One mechanism for carrying out the Coggeshall Report's call for closer working relationships with related health organizations has been the founding of the Federation of Associations of Schools of the Health Professions which the AAMC was instrumental in establishing in 1968.

Constituent organizations include associations of university-based schools educating health professionals as well as associations of other accredited schools which award a doctor's degree in a health profession.

The Council of the Federation, representing all member organizations, meets quarterly. Liaison representatives of federal agencies and several organizations of the health professions are invited to participate in the Council's deliberations.

The Council of the Federation considers issues and problems of interest to the member associations, their constituent institutions, faculties and students. Recent discussions have concerned accreditation, licensure, the operating policies and procedures of federal health and education agencies, health manpower legislation, support for health professions education, student recruitment, minority group representation in the health professions, and the supply and retention of military health personnel.

On occasion, the Council has issued position statements on current issues and has presented testimony before congressional committees.

Member organizations include:

American Association of Colleges of Pharmacy
American Association of Colleges of Podiatric Medicine
American Association of Dental Schools
American Association of Osteopathic Colleges
Association of American Veterinary Medical Colleges
Association of Schools and Colleges of Optometry
Association of American Medical Colleges
Association of Schools of Allied Health Professions
Association of Schools of Public Health
Association of University Programs in Hospital Administration
National League for Nursing (Council on Baccalaureate and Higher Degree Programs)

Coalition for Health Funding

Another method of the AAMC's relating to organizations which share an interest in the health field has been through participation in the Coalition for Health Funding, a grouping of 22 health related organizations whose purpose has been to secure adequate Federal funding for health programs. Included among the members of the Coalition are American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Dental Schools, American Nurses Association, and Association of Schools of Allied Health Professions. Attached (Attachment II) is a summary of the Coalition's activities through September 1971. This year Dr. John A. D. Cooper, President of the AAMC, served as Chairman of the Coalition's Steering Committee.

It can be seen that the AAMC has been aware of its responsibilities with respect to developing appropriate relationships with the full spectrum of health professions organizations. With respect to the more specific recommendation of the OSR relating to developing closer ties with schools of osteopathic medicine, consideration of the following history may be useful.

Schools of Osteopathy

BACKGROUND: Formal training in osteopathic medicine began in 1892; the establishment of the first school of this type was in the State of Missouri. The number of schools proliferated until 1910 at which time twelve such schools were in existence. Subsequent to 1910 the number dwindled to six. These six existed for some years until 1962 when the Los Angeles

College of Physicians and Surgeons, an Osteopathic School, became the California College of Medicine. The opening of a new school in 1969 as a college of Michigan State University raised the number to seven.

There are approximately 14,000 doctors of osteopathy known to exist in the United States. These doctors of osteopathy are licensed to practice in nearly all states; however, there are some limitations on what kinds of practice they can do in certain states. Since 1968 Osteopaths have possessed the same privileges to practice surgery and medicine as do MDs in forty-two states and the District of Columbia. In thirty states, they take the same licensing board examinations as do the MDs.

THE AMA: The American Medical Association has expended considerable effort in consideration of the field of osteopathic medicine and its probable and possible relationship with eclectic medical practice. A cluster of papers on this subject was presented at the 65th Annual Congress on Medical Education of the AMA in February 1969. These papers were published in the Journal of the American Medical Association July 7, 1969.

The American Medical Association has taken a number of specific steps which have resulted in the drawing of the practice of osteopathic medicine and eclectic medicine closer together. The steps taken by the AMA are as follows:

1. County and state medical societies may accept qualified osteopaths as active members and therefore provide for their membership in the American Medical Association.

2. Accredited hospitals may accept qualified osteopaths for appointment to their medical staffs.

3. Internships approved by the AMA were made available to qualified graduates of schools of osteopathy as of January 1, 1969.

4. Some of the specialty boards have declared their intent to accept for examination those osteopathic graduates who have completed AMA approved internships and residency programs and who have met other requirements applicable to all board candidates.

In the matter of the conversion of the Los Angeles College of Physicians and Surgeons to the MD graduating California College of Medicine, an interesting method was used. In 1962, 2,700 graduates of this institution with the doctor of osteopathy degree were re-graduated with the MD degree. Apparently, this was done so that these individuals could qualify for a regular license to

practice medicine and surgery under the medical practice act provisions of the State of California.

There are reports that other colleges of osteopathic medicine have held serious considerations of conversion from their format status to regular MD degree granting institutions fully accredited by the usual procedures employed by the Liaison Committee on Medical Education. However, there are also reports that the older members of the American Osteopathic Association look with disfavor upon such alteration of the status of any more of their doctor of osteopathy degree-granting institutions and have probably engaged in some efforts to retard such developments.

THE AAMC: The Executive Council of the Association of American Medical Colleges in its meeting on December 18, 1969, enacted the following policies:

1. The AAMC will be receptive to the interests of osteopathic schools that wish to become more closely associated with eclectic medicine.

2. Relations and discussions between AAMC staff and representatives of schools of osteopathy will be conducted openly with correspondence concerning accreditation and site visits handled as in the case of all medical schools.

3. Staff will be expected to handle requests for accreditation in the fashion analogous to that of a developing medical school.

4. Staff will be expected to work co-operatively with the American Medical Association and to keep in touch with the local groups concerned with the evolution of these osteopathic schools with whom the AAMC is working.

IN SUMMARY: Both the AMA and the AAMC appear to have established certain principles and have adopted certain practices which allow a greater inter-mingling of activities of osteopathic schools with the schools of medicine, and the inter-mingling of the practioners of osteopathic medicine with the practioners of eclectic medicine. In general, it would appear, however, that most of the actions of the AMA and the AAMC are related to the proposed modification of the osteopathic schools into the eclectic version of medicine which is taught in the cluster of medical schools belonging to the Association of American Medical Colleges. Resistance on the part of members of the American Osteopathic Association may not make such absorptions possible, however, with the result that osteopathic colleges may continue their separate existence for quite some time. If this prediction holds true then the trend toward absorption into eclectic medicine of the osteopathic physicians would deviate from the earlier experience of absorption of

homeopathic medicine into eclectic schools of practice, as was done in the earlier part of this century.

Recommendation

From the above discussion it is apparent that the students' desire for a cooperative and coordinated approach to working through problems of health education and health care services among the various health professions groups is highly consistent with the traditions, philosophy and recent history of the AAMC. To date, however, these relationships have developed at the organizational level rather than at a level which fosters personal interchange among the students and professionals. While this is a natural result of the current structure of this and other associations whose membership is primarily institutional in character, the value of such personal interchange is not to be denied. Indeed, the OSR resolution arose out of the context of the annual meeting which attracted the attendance of approximately 2,800 medical educators. A primary motivation of many in attendance was just such an interchange.

It would appear then that one of the considerations behind the students' action was the desire to develop the OSR as a forum for the interchange of students views on a scale not limited to a pre-MD participation.

It is therefore recommended as a further step toward enhancing productive interrelationships among the health professions that the Administrative Board advise the OSR to seek, with the assistance of the AAMC staff, the development of such a forum for students of the health professions under the aegis of the Federation of Associations of Schools of the Health Professions.

Action: At its December 16, 1961 meeting the COD Administrative Board adopted the above recommendation.

Recommendation: That the OSR further consider the matter of the relationship of the AAMC to other health organizations and the appropriateness of the approach recommended by the COD Administrative Board to enhance these relationships.

ATTACHMENT I

ASSEMBLY RESOLUTION

1. Resolution as proposed by the Resolutions Committee - October 30, 1971.

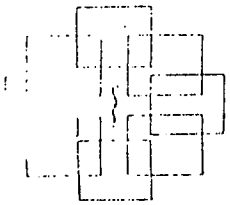
> "For the institutional members of the AAMC to prepare effectively students for the delivery of health care in the U.S.A. it is important that all students of human medicine and their respective schools be provided the opportunity for *participation* [representation] in the Association.
>
> "Therefore, be it resolved that the AAMC strive toward providing for the active *participation* [membership] of schools of *osteopathic medicine* [osteopathy] in the Association and that the President and the Executive Council explore all possible steps towards accomplishing this goal."

2. Action of the Assembly.

   A. Motion to amend substituting words *italicized* for those in [ ] adopted by voice vote.

   B. Motion to table principle motion adopted.

ATTACHMENT II



COALITION FOR HEALTH FUNDING

One Dupont Circle • Washington, D.C. 20036

FOR IMMEDIATE RELEASE
September 30, 1971
Contact: Charles Fentress
(202) 466-5170

Although the appropriation process for fiscal year 1972 has not yet been completed, it is perhaps appropriate at this stage to assess the effect of the efforts of the Coalition for Health Funding in attempting to secure a higher level of federal support for HEW health programs.

In summary, for the programs of the National Institutes of Health for which the Coalition made a recommendation, the actual appropriation agreed to in the House-Senate conference was under the Coalition's recommendation by $66.7 million. The appropriation allowed in the conference report for the programs of the Health Services and Mental Health Administration was $17.9 million less than the Coalition's recommendation. No appropriations were made for those health manpower programs the authorizing legislation for which is still pending in the Congress.

While the full measure of the Coalition's objectives was not achieved, the increases above the President's budget made by the Congress constituted a substantial achievement. The Coalition had sought a total increase above the President's budget for NIH and HSMHA programs of $632.5 million. For these same programs the Congress allowed an increase of $547.8 million above the President's budget. Actions in both House and Senate to increase significantly the Presidential request in major health programs, we believe, were significantly influenced by Coalition activities and its specific recommendations for appropriation increases.

Although the amendment on the House floor sponsored by the Coalition to add $200 million to the appropriation bill as reported by the House appropriation

committee failed of passage, that failure, in some part, was due to the fact that the House committee brought to the floor an appropriation bill that was $321 million over the President's request. In reporting this to the House, the committee chairman made reference to efforts of interested groups to secure increased appropriations as a matter which bore upon the committee's activities. This, indeed, is high recognition of the Coalition's efforts.

Perhaps the greatest achievement in the Coalition's activities was that of substaining a unified, common front among some twenty-two diverse health groups many of which had very specific and limited objectives in the appropriation field. The fact that such groups merged their separate efforts into a common and unified endeavor to gain greater recognition for health funding in the federal appropriation process is an important milestone in achieving a more unified health front in the nation.

We intend to direct this combined strength toward obtaining full appropriation of the levels of support authorized for health manpower programs as soon as that legislation passes the Congress. We will also press the Executive Branch for full apportionment of funds appropriated for health programs in FY 1972.

We hope next year that we can build upon the progress thus far to use this unified force in the most constructive manner possible in providing the Congress with a non-governmental view of the levels of support required for major national health programs.

* * * *

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #72-1 January 12, 1972

TO: Voting members of the Assembly

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

SUBJECT: Review of the year in Washington

For health matters in Washington, 1971 was a remarkable year. This Memorandum reviews the major developments, presenting, first, a summary of the highlights and, second, a capsule description of important legislation.

Enactment of landmark legislation to provide continuing and substantial federal support for health professions education -- the Comprehensive Health Manpower Training Act of 1971 -- was perhaps the most significant 1971 development in Washington affecting medical schools. This measure together with companion legislation that was also enacted -- the Nurse Training Act of 1971 -- thrust the government deeper into efforts to cope with the nation's health crisis of inadequate manpower, uneven delivery and soaring costs. Both of these bills deal with the supply of health personnel. Meanwhile, other bills dealing with the delivery of health services (through health maintenance organizations, among other means) and financing of health care (through some form of national health insurance) await further Congressional action in 1972.

In other major 1971 Washington developments, Congress approved compromise legislation to retain an expanded cancer research program in the National Institutes of Health and approved appropriations for the numerous health-related activities of the Health, Education and Welfare Department that were significantly above the amounts requested by President Nixon.

Most of President Nixon's health program was only partially through the legislative process when Congress adjourned December 17. Work on the program was to be resumed when the second session of the 92nd Congress convened on January 18. The status of the program (as of adjournment): -- Health Manpower Assistance Act (HR 5614; S 1183): included, with substantial changes, in the Comprehensive Health Manpower Training Act (PL 92-157) and the Nurse Training Act (PL 92-158); -- Act To Conquer Cancer (HR 8343; S 1828): included, with substantial changes, in the National Cancer Act (PL 92-218); -- Health Maintenance Organization Assistance Act (HR 5615; S 1182): in committee; -- National Health Insurance Partnership Act (HR 7741; S 1623): in committee; -- Department of Human Resources Act (HR 6961; S 1432): in committee. An Administration request for appropriation of an additional $100 million for cancer research was given speedy Congressional approval.

Looming over Washington and the nation at year's end were the still uncertain effects of President Nixon's new economic policy. The policy, which imposed unprecedented peacetime controls on the American economy, was stunning in its own right, but was made especially so, coming as it did from a President who was opposed historically to such controls. Phase I of the policy -- a 90-day freeze on wages and prices -- was announced on

August 15. The current Phase II, which went into effect on November 14, provides for flexible wage and price guidelines, administered by the Cost of Living Council, the Pay Board, the Price Commission, and a number of advisory groups, including the Committee on the Health Services Industry, headed by Ms. Barbara Dunn, Commissioner of the Connecticut Department of Consumer Protection. On December 15 the Price Commission approved policies for health care services by institutional and non-institutional providers as recommended by the Committee on the Health Services Industry.

In appropriations action, Congress provided a total of nearly $4.2 billion for the health-related activities of the DHEW in fiscal 1972. This included appropriations of more than $1.4 billion for the research institutes of the NIH (President's request: $1.3 billion; fiscal 1971 appropriations: $1.2 billion); $673.6 million for the NIH health manpower programs (President's request: $530.8 million; fiscal 1971 appropriations: $429.4 million); and nearly $2 billion for the activities of the Health Services and Mental Health Administration (President's request: $1.6 billion; fiscal 1971 appropriations: $1.5 billion). For the medical programs of the Veterans Administration, Congress appropriated $2.5 billion for medical care, research, hospital construction and related activities. This was $190 million more than the President's request and $406.6 million more than fiscal 1971 appropriations. For successfully working to increase the DHEW appropriations, news accounts gave much of the credit to the Coalition for Health Funding, an ad hoc grouping of health-related organizations, of which the Association is a member.

Personalities were important in a number of areas. President Nixon selected Merlin K. DuVal, M.D., Dean and Director of the Medical Center of the University of Arizona College of Medicine, to succeed Roger O. Egeberg, M.D., as HEW Assistant Secretary for Health and Scientific Affairs. Chairman of the Association's Council of Deans when selected for the DHEW position, Dr. DuVal was routinely confirmed by a voice vote in the Senate on June 18. In Congress, Senator Edward M. Kennedy (D Mass.) and Representative Paul G. Rogers (D Fla.) appeared locked in a contest for personal supremacy in the field of health legislation. Each was serving his first term as chairman of his chamber's principal health subcommittee, and they clashed repeatedly on legislative approaches to health issues, including the issues of cancer research and assistance for health professions and nursing education.

Among the important administrative (as opposed to legislative) actions of the year were developments dealing with the Hill-Burton program, the humane treatment of laboratory animals and medical malpractice claims. The DHEW's Health Services and Mental Health Administration on July 29 announced proposed regulations for implementing 1970 legislative amendments to the Hill-Burton program. Final regulations were issued on January 6, 1972. On August 22, HEW Secretary Elliot L. Richardson announced creation of a Commission on Medical Malpractice, headed by Wendell Freeland, a Pittsburgh, Pa., lawyer, to probe the entire range of problems associated with medical malpractice claims against health care providers and institutions. The Association testified before the Commission

on December 17. The Agriculture Department's Agricultural Research Service on December 24 issued final regulations for carrying out Association-opposed 1970 laboratory animal welfare legislation. The Department simultaneously announced plans to consider additional regulations establishing exercise standards and minimum space requirements for confined animals.

Following are summaries of Congressional action during 1971 on health-related legislation and on other legislation of interest to the Association, as well as a list of selected health-related legislation expiring in 1972 or 1973.

Department of Health, Education and Welfare Legislation

Congressional action completed

Cancer: President Nixon on December 23 signed into law the National Cancer Act of 1971 (S 1828 -- PL 92-218). The final legislation is the outcome of a year-long struggle over the unity of biomedical research, which saw Senator Kennedy and Congressman Rogers staking out positions on opposite sides of the issue. As enacted, the bill retains Congressman Rogers' proposal for a cancer research program in the National Cancer Institute, as part of the National Institutes of Health. An alternate approach, championed by Senator Kennedy, would have established a new, independent, federal cancer research agency. The Association strongly supported the approach taken by Congressman Rogers to preserve the unity of biomedical research, as represented by the National Institutes of Health. In its final form, the legislation authorizes appropriations of $1.6 billion through June 30, 1974, for a National Cancer Program of expanded cancer research; diagnosis, prevention and treatment of cancer; and establishment of 15 cancer research and demonstration centers. New prominence is to be given to the cancer research effort by providing for Presidential appointment of the Directors of the National Cancer Institute and the National Institutes of Health and by providing for direct transmission to the President's Office of Management and Budget of the annual budget of the National Cancer Institute.

Disaster relief: On December 18, President Nixon signed into law legislation (S 1237 -- PL 92-209) that authorizes federal assistance for the repair, rebuilding or reconstruction of any eligible private nonprofit medical care facility damaged or destroyed by a major disaster after January 1, 1971. The bill was an outgrowth of the widespread damage caused by the February 10, 1971 earthquake in California. The law amends the Disaster Relief Act of 1970 by adding a new section, making available the same kind of aid for which publicly owned medical care facilities are now eligible under the 1970 Act.

Health professions, nursing: President Nixon on November 18 signed into law two measures dealing with the supply of health personnel: the Comprehensive Health Manpower Training Act of 1971 (HR 8629 -- PL 92-157); and the Nurse Training Act of 1971 (HR 8630 -- PL 92-158). Together, the two bills authorize some $3.8 billion through June 30, 1974, in federal

assistance for the educational activities of schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine and nursing. Congressional activity on legislation for assistance to health professions schools was a central concern of the Association's in 1971. As enacted, the health professions assistance legislation is considered by many to be landmark legislation which for the first time commits the federal government to substantial continuing financial support of medical education. Existing programs of construction assistance, institutional support and student assistance are extended and modified by the new health professions legislation. In addition, it establishes new programs of assistance for training health professions teaching personnel, for supporting graduate medical education and for applying computer technology to the health professions. The companion legislation dealing with federal assistance for nursing education provides similar programs of construction assistance, institutional support and student assistance. To carry out the new legislation in the year ending June 30, 1972, President Nixon requested appropriations of $474.4 million, compared to authorized appropriations of more than $1 billion. Congress enacted $617.2 million for health professions and nursing assistance programs, including $472.3 million for health professions assistance and $144.9 million for nursing assistance.

PHS hospitals: Congress December 9 completed action on a "sense-of-the-Congress" resolution (S Con Res 6) declaring that all Public Health Service hospitals should remain open and within the Public Health Service during the 12 montns ending June 30, 1972. The resolution, which does not have the force of law, is an outgrowth of an Administration plan, opposed in Congress, to close some PHS hospitals and to turn over others to community control. The intent of the resolution is to provide time for the Congress and the Administration to study the operation of the hospitals and clinics, with a view to determining what their future mission and role should be.

Congressional action not completed

DHEW reorganization: Administration bills (S 1432; HR 6961) to reorganize the DHEW into a new, super-department, the Department of Human Resources, are pending before the largely disinterested Government Operations Committees of the House and Senate. The bills are part of President Nixon's plan for a major overhaul of the organization of the Executive Branch, which calls for other new, super-departments as well. Overview hearings on the President's general plan have been held, but specific hearings on the Department of Human Resources legislation have not been held. Meantime, Congressman Paul Rogers has announced plans to introduce his own DHEW reorganization bill to create a separate Department of Health, comprised of the National Institutes of Health, the Health Services and Mental Health Administration and the Food and Drug Administration. The Rogers bill has yet to be introduced, however.

Drug abuse control: The Senate December 2 passed and sent to the House Administration-supported legislation, the Drug Abuse Office and Treatment Act (S 2097). The legislation authorizes appropriations of more than $1.7 billion through June 30, 1976, for federal and state programs dealing

with drug abuse. The bill creates a Special Action Office for Drug Abuse Prevention to coordinate in the Executive Office of the President the federal effort against drug abuse; a strategy council to develop long-term plans for elimination of drug abuse; a National Institute on Drug Abuse in the Health Services and Mental Health Administration's National Institute of Mental Health; and a National Advisory Council on Drug Abuse to advise the HEW Secretary. In the House, the Public Health and Environment Subcommittee on December 7 approved for full committee action its own legislation (HR 12089) to establish a Special Action Office for Drug Abuse Prevention and to concentrate the resources of the nation against the problem of drug abuse. No further House action occurred prior to adjournment.

Ethics of research: The Senate December 2 passed and sent to the House Administration-opposed legislation (SJ Res 75) to create a 15-member, Presidentially appointed, blue-ribbon, National Advisory Commission on Health Science and Society. The Commission is to make a two-year study and investigation of the ethical, social and legal implications of advances in biomedical research and technology and to prepare a report for the President and Congress. In the House, the Senate-passed legislation is pending before the Interstate and Foreign Commerce Committee.

HMOs: The Senate Health Subcommittee has conducted a lengthy set of hearings on a variety of legislation dealing with the organization of health services, including an Administration measure, the Health Maintenance Organization Assistance Act (S 1182). The Association testified on October 5. It is widely assumed that the resulting Subcommittee legislation will support the form of comprehensive, prepaid, group practice that has come to be known as a health maintenance organization. A number of alternate approaches, however, are suggested in some of the bills pending before the Subcommittee -- such as community health and education corporations, favored by Senator Claiborne Pell (D R.I.); and comprehensive health service systems, favored by Senator Jacob Javits (R N.Y.). The Association is supporting a bill (S 935) introduced by Senator Kennedy to provide special assistance for HMOs based in academic health centers. The kinds of federal assistance most commonly discussed are construction assistance through grants and loans, funds for planning and feasibility studies, assistance to meet initial operating expenses, and protection from abnormally high costs resulting from exceptional health problems in the enrolled population. Among the principal issues under discussion are the amount and variety of health services to be required of an HMO in order to qualify for federal assistance, the availability of federal assistance to proprietary HMOs, and the levels of funding for whatever assistance programs are agreed upon. The House Public Health and Environment Subcommittee has yet to hold similar health services legislation hearings. Among the bills pending before the House Subcommittee are ones supported by the Administration (HR 5615) and the Association (HR 4170), as House counterparts of identical Senate bills, and the Health Maintenance Organization Act (HR 11728), prepared by Representative William R. Roy, (D Kan.) and supported by a number of Public Health and Environment Subcommittee members, including Chairman Paul Rogers.

Kidney disease: While most legislation dealing with kidney disease calls for establishment of a new NIH research institute (see NIH, below), House Ways and Means Committee Chairman Wilbur D. Mills (D Ark.) has taken a different approach. Chairman Mills has introduced legislation (HR 12043) which would amend title XVII of the Social Security Act to provide financial assistance to individuals suffering from chronic kidney disease who are unable to pay the costs of necessary treatment, and to authorize project grants to increase the availability and effectiveness of such treatment. Mr. Mills' Committee has jurisdiction over all Social Security legislation; and because of his stature as chairman of the Committee, HR 12043 is attracting special attention and interest. The Social Security Act's title XVII presently provides grants to states for planning comprehensive action to combat mental retardation.

Medical devices: Pending before the health subcommittees of the House and Senate is legislation, including an Administration measure, the Medical Device Safety Act (HR 12316; S 3028), to improve the safety of medical devices. Reports of unsafe and untested, but marketed, medical devices have fueled a long-simmering Congressional issue that has been kept alive recently by Senator Gaylord Nelson (D Wis.). Senator Nelson has introduced in successive Congresses a number of unsuccessful bills to regulate medical devices. His bill in the current Congress is numbered S 1824. In essence the various legislative approaches agree on a need for uniform quality standards set by the HEW Secretary and for some form of premarket clearance of devices.

Medicare-medicaid: The House June 22 passed a major Social Security and welfare reform bill (HR 1) that provides for increased Social Security retirement benefits and taxes and for reforming the welfare system generally along the lines of President Nixon's Family Assistance Plan. Hearings on the House-passed bill have been held by the Senate Finance Committee, and its chairman, Russell B. Long (D La.), has announced that the Committee will send the measure to the Senate floor by March 1, 1972. The legislation includes a number of provisions of special interest to the Association, including two that are of serious concern. One of these would limit payment for supervisory and teaching physicians' services under Medicare. The intent is to reduce the incidence of double payment in the treatment of nonprivate patients, whereby a supervisory or teaching physician, as the physician of record, was paid under Part B for services actually performed by an intern or resident, for which the hospital could obtain reimbursement under Part A. Under the House-passed bill, payment for the services of teaching physicians to Medicare patients is to be made under Part A on the basis of actual or "equivalent" cost, except in certain circumstances. Payment under Part B would be authorized only where either the Medicare patients were bona fide "private" patients of the billing physician, or during the two-year period ending December 31, 1967, and each subsequent year, all the institution's patients were regularly billed on a fee-for-service basis for professional services and most patients paid such charges. The other provision of serious concern to the Association allows states to develop their own methods and standards for reimbursement to hospitals for inpatient care under medicaid, changing the present law which requires states to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in Medicare. Reimbursement by the states would in no case exceed reasonable cost reimbursement as provided under Medicare. As a result, it is expected that medicaid reimbursement would drop. This change is of particular concern since a large number of medicaid patients are treated in teaching hospitals already facing financial problems.

National health insurance: The House Ways and Means Committee has concluded public hearings on legislation to establish a program of national health insurance and is expected to hold a series of private, executive hearings in early 1972 to develop a proposal for consideration by the full House of Representatives. Witnesses in the hearings displayed a remarkable degree of agreement on the need for some form of national health insurance plan. The Association testified on November 15. The task of the Ways and Means Committee now is to put together out of the great variety of pending legislative approaches an approach that is acceptable to the Nixon Administration as well as to liberals and conservatives in Congress. The legislative approaches range from the Administration's National Health Insurance Partnership Act (HR 7741; S 1623) to the AFL-CIO's Health Security Act (HR 22; S 3), sponsored by Representative Martha W. Griffiths (D Mich) and Senator Kennedy. There also are major proposals offered by the American Medical Association, the Health Care Insurance Act (HR 4960; S 987), and by the insurance industry, the National Health Care Act (HR 4349; S 1490). Each of the proposed plans carries a sizable price tag, varying, according to a disputed DHEW study, from $2.6 billion for the Administration's bill to $59.4 billion for the Kennedy-Griffiths bill. Among the principal issues to be resolved are compulsory-versus-voluntary participation; coverage; the range of available benefits; administration of the program; determination of payments to providers; the mix of public and private financing; use of coinsurance, copayment and deductibles; support for traditional-versus-innovative forms of health service; maintenance of the quality of care; and the role of the academic health center.

NIH: The principal 1971 legislation dealing with the National Institutes of Health concerned the organization of an expanded cancer research effort as requested by President Nixon in his State of the Union Message (see Cancer, above). Other 1971 NIH-related legislation, none of it bearing the Administration's stamp, proposed establishment of a variety of special new research institutes. Among the more commonly proposed new institutes were a National Kidney Institute, a National Institute of Digestive Diseases and Nutrition, a National Sickle Cell Anemia Institute, a National Institute of Gerontology, and a National Institute of Aging. The legislation has been referred to the health subcommittees of the House and Senate. Two days of hearings were held in November by the House Public Health and Environment Subcommittee on bills, which were opposed by Administration witnesses, to create a National Institute of Digestive Diseases and Nutrition. No further action was taken before adjournment. (For other 1971 legislation dealing with kidney disease and sickle cell anemia, see those headings).

Sickle cell anemia: The Senate December 8 passed and sent to the House Administration-opposed legislation, the National Sickle Cell Anemia Act (S 2676). The legislation, which authorizes appropriations of $142 million through June 30, 1975, contains four basic provisions -- a program of grants for research, voluntary screening and counseling, and public education; a program of demonstration grants for development of centers for research and research training in sickle cell anemia; a requirement that the Defense Department provide voluntary screening, counseling, treatment

and education concerning the disease for servicemen, civilian employees and inductees; and similar requirements for action by the Veterans Administration and the Public Health Service. The House Public Health and Environment Subcommittee held a day of hearings in November on sickle cell anemia legislation, but took no further action before adjournment.

Veterans Administration Legislation

Congressional action completed

Exchange of information: President Nixon on August 6 signed into law Administration-supported legislation (HR 4762 -- PL 92-69) to extend through June 30, 1975, current authority of the Administrator of the Veterans Administration to carry out a program of exchange of medical information, with, among others, medical schools.

Congressional action not completed

Administration of graduate training: The House on October 4 passed and sent to the Senate Administration-supported legislation (HR 10879) to authorize the VA Administrator to enter into agreements with hospitals, medical schools or medical installations for the central administration of the several types of intern and residency training in which the VA participates. The bill also would allow the Administrator to spend appropriated funds for the purpose of paying to the central administrative body the costs involved for the periods during which the trainee serves with the VA. In the Senate, hearings have been held by the Veterans' Affairs Committee.

Continuing education: Hearings have been held by the Senate Veterans Subcommittee on Health and Hospitals on legislation, the Veterans Administration Continuing Medical Education Act (S 2355), sponsored by Subcommittee Chairman Alan Cranston (D Calif.). The legislation provides for advanced residency-type training for medical personnel of the VA and other federal departments and agencies at regional medical education centers, established at VA hospitals throughout the United States. The Association testified at the hearings.

Medical care: On October 4, the House passed and sent to the Senate Administration-opposed legislation, the Veterans Medical Care Act of 1971 (HR 10880). The legislation could serve as a means for improving the relationships between medical schools and affiliated VA hospitals. The bill provides for improved medical care to veterans, for hospital and medical care to certain dependents and survivors of veterans, and for improved recruitment and retention of career personnel in the VA's Department of Medicine and Surgery. Senate hearings, at which the Association testified, have been held on an Administration-supported version of the House measure (S 1924) and an alternate approach, the Veterans Health Care Reform Act (S 2354), prepared by Alan Cranston (D Calif.), chairman of the Senate Veterans Subcommittee on Health and Hospitals.

VA hospitals: The House October 4 passed and sent to the Senate Administration-opposed legislation (HR 6568), dealing with the closing of VA hospitals. The bill would limit the authority of the VA and the Office of Management and Budget with respect to the construction, acquisition, alteration or closing of veterans hospitals, and prohibit transfer of VA real property, unless such action was first approved by the House Veterans Affairs Committee. The bill is described as having been designed to give the Committee greater control for its long-range program for VA facilities.

VA-medical schools: The House July 19 passed and sent to the Senate Administration-opposed legislation, the Veterans Administration Medical School Assistance and Health Service Personnel Education and Training Act (HJ Res 748). In the Senate, hearings have been concluded by the Veterans Subcommittee on Health and Hospitals on the House-passed measure and on a similar, though broader, measure, the Veterans Administration Health Manpower Training Act (S 2219), sponsored by Subcommittee Chairman Alan Cranston (D Calif.). In its tesimony, the Association tended to favor the broader Senate measure. Under the House-passed legislation, the VA would be authorized to provide a variety of assistance -- such as VA land and buildings and necessary alterations, remodeling or repairs -- to states for the establishment of up to five new medical schools in geographically dispersed areas. The bill would authorize appropriations of $15 million annually for seven years, through fiscal 1978, for grants to help meet the cost of faculty salaries. Support for faculty salaries would decline from 90 percent in the first year to 50 percent in the seventh year (total authorization: $105 million). In another major section, the House-passed legislation would authorize a program of 50 percent matching grants to affiliated medical schools to help them improve and enlarge their facilities. The bill would authorize $15 million annually for seven years, through fiscal 1978, for the program (total authorization: $105 million). In a third major section, the House-passed legislation would authorize a program of 50-percent matching grants to affiliated universities, community colleges, hospitals and others to help them expand the training of allied health personnel. The bill would authorize appropriations of $3 million in fiscal 1972 and $4 million annually thereafter through fiscal 1978 for the program (total authorization: $27 million). The broader Senate measure would authorize VA assistance in the establishment of new public nonprofit medical, and other health professions, and allied health schools and area health education centers; and in the expansion and improvement of health manpower training programs in VA facilities and in affiliated education institutions, including area health education centers. The bill would authorize $125 million annually through fiscal 1977 for such assistance (total authorization: $750 million).

Defense Department Legislation

Congressional action completed

Doctor draft: President Nixon on September 28 signed into law legislation (HR 6531 -- PL 92-129) to extend the doctor draft for two years, until June 30, 1973. The authority to continue drafting doctors and other

health personnel was contained in a regular -- though controversial -- extension of the President's authority to draft young men for military service. In addition to a two-year extension of the doctor draft and special pay for military physicians, the bill also provides for a Defense-HEW study of military health manpower requirements. In a related development, the General Accounting Office on December 16 released a study of military medical personnel, showing an excessive use by the armed services of health professionals in administrative positions and calling for more efficient use of health professionals and increased use of paraprofessional personnel.

Congressional action not completed

Military medical school: The House November 3 passed and sent to the Senate legislation authorizing establishment of a government medical school for armed services personnel and a program of military medical scholarships, the Uniformed Services Health Professions Revitalization Act (HR 2). The Association testified against the bill. Under the legislation, a Uniformed Services University of the Health Sciences would be established to graduate at least 100 students a year within 10 years. Students attending the school would be commissioned officers and after graduation would be obligated to serve seven years in the armed services, excluding time spent in military intern or residency training. Up to 20 percent of each graduating class would be permitted to fulfill their obligation by performing "civilian federal duty." The business of the schools would be conducted by a board by regents that would include civilians from the fields of health and health education. The board would be permitted to contract for educational services with certain civilian medical schools. Design and construction of the government school would cost a projected $35 million. Once in full operation, the annual operating cost is projected to be $21.5 million. Participants in the scholarship program must be accepted for admission to or be enrolled in a medical school and must agree to serve in the armed services after graduation for at least one year for each year in the program. The total number of persons in the program at any one time would not exceed 5,000. The annual cost of the program would be an estimated $40 million to $50 million. The scholarship program was proposed by the Nixon Administration. Counter to the Administration proposal, the committee added language prohibiting scholarship aid to students at schools which have either adopted a policy against on-campus armed forces recruiters or disestablished their ROTC programs against Pentagon wishes. The military medical school proposal is a long-time personal project of Representative F. Edward Hebert (D La.), who became chairman of the House Armed Services Committee in 1971 on the death of Chairman L. Mendel Rivers (D S.C.).

Other Legislation

Congressional action not completed

Advisory committees: The Senate Government Operations Subcommittee on Intergovernmental Relations held hearings in October on a variety of legislative proposals to improve the effectiveness of advisory committees in the Executive Branch by providing for increased public access and for

uniform standards and procedures. The legislation would affect the operation and personnel of the various national advisory councils created to assist in the operation of Public Health Service grant programs, including the study sections established by the National Institutes of Health to review the scientific merit of applications for research grants. In a letter submitted in lieu of testimony, the Association urged that NIH's scientific review groups be excluded from provisions of the legislation requiring advisory committees' membership to include representatives from the public and meetings to be open to the public.

Impounded funds: Included in the foreign aid authorization bill (S 2819) as it nears the end of the legislative process is language that could force the President's Office of Management and Budget to free any DHEW funds that it has impounded. The Senate agreed to a compromise version of S 2819 on December 17, but the House adjourned later the same day without voting on the compromise. The special language provides that after April 30, 1972, no foreign aid funds shall be available for obligation unless the Comptroller General certifies that all impounded fiscal 1971 appropriations for the Departments of Agriculture, Housing and Urban Development, and Health, Education and Welfare have been released for obligation and expenditure. It is not known how much appropriated for DHEW activities has been impounded, although news reports have placed the total at about $130 million. Later news accounts have reported that the Office of Management and Budget has released nearly all funds previously impounded from a number of departments, including the DHEW.

International health agency: The House Foreign Affairs Subcommittee on International Organizations and Movements held hearings in August on Administration-opposed legislation, the International Health Agency Act (HR 10042). The bill authorizes appropriations of $25 million per year through June 30, 1976, to establish an International Health Agency and to extend health and medical assistance to foreign countries. Among numerous cosponsors of the bill in the House are Representative Donald M. Fraser (D Minn.), chairman of the Subcommittee. Similar legislation has been introduced in the Senate (S 3023) by Senator Jacob K. Javits (R N.Y.), ranking minority member of the Labor and Public Welfare Committee, to which the Senate legislation was referred.

Lobbying by tax exempt groups: Legislation has been introduced in both chambers of Congress to permit certain tax exempt organizations to engage in certain communications with Members of Congress and its committees without jeopardizing their tax exempt status. Modeled after recommendations of the American Bar Association, the legislation has been introduced in the Senate as S 1408 by Edmund S. Muskie(D Maine) and in the House as HR 8176 by James W. Symington (D Mo.). The legislation would clarify legislative activities permitted a tax exempt organization, which presently is prevented from engaging in a substantial amount of activity to influence legislation. The present restriction is troublesome because no commonly used definition of "substantial" is available. The Association would be affected by the legislation because it qualifies for tax exempt status as a private charity, exempt under section 501 (c)(3) of the Internal Revenue Code,

which is not a private foundation by reason of section 509(a). The legislation has been referred to the tax-writing committees of the House and Senate, but no further action has occurred.

Registration of lobbyists: The House Committee on Standards of Official Conduct (Ethics Committee) December 10 approved for consideration by the full House of Representatives the Legislative Activities Disclosure Act (HR 11453). The bill, sponsored by Committee Chairman Melvin Price (D Ill.), repeals the Federal Regulation of Lobbying Act of 1946, the current law regulating most lobbyists, and replaces it with a new -- and, its sponsors assert, more effective -- set of regulations. The bill apparently would affect the activities of the Association. In general, the bill requires registration and semi-annual reports by persons meeting the definition of paid legislative agent and reports by their employers; semi-annual reports by individuals who, as part of their duties as officers or employees, engage in covered legislative activity on six or more days in a six month period and reports by their employers; and reports by paid grass-roots lobbyists, involved in soliciting others to communicate directly with Congress. The new law transfers administration of the regulations from the Clerk of the House and the Secretary of the Senate to the Comptroller General. Congress adjourned before taking further action on the legislation.

Expiring Legislation

On June 30, 1972, according to a list prepared by the President's Office of Management and Budget, only one major piece of health-related legislation is to expire: communicable disease control and vaccination assistance (PL 91-464).

On June 30, 1973, according to the Office of Management and Budget's lists, thirteen major pieces of health-related legislation are to expire. They include: the Medical Library Assistance Act (PL 91-212), health facility construction and modernization -- the Hill-Burton program (PL 91-296), community mental health centers staffing and construction grants (PL 91-211), mental retardation facilities staffing and construction grants (PL 91-517), allied health professions (PL 91-519, title II), Partnership for Health (PL 91-515 pages 7-9), Regional Medical Programs (PL 91-515 title I), alcoholic and narcotic addict rehabilitation (PL 91-211), health facilities and services research and demonstrations (PL 91-515, pages 4-6), national health surveys and studies (PL 91-515 pages 6 and 7), migrant health (PL 91-209), public health training (PL 91-208), and the doctor draft (PL 92-129).

VIII. FACULTY REPRESENTATION IN THE AAMC

The attached papers on Faculty Representation in the AAMC and Guidelines for the Organization of Faculty Representatives were presented to the Executive Council on December 17. As mentioned herein, these papers emanated from the AAMC's December Retreat.

After discussing the issues raised in these papers, the Executive Council took the following action:

ACTION: On motion, seconded and carried unanimously, the Executive Council favorably recommends the proposed "Guidelines for the Organization of Faculty Representatives" to the constituent Councils for consideration.

It was agreed that this issue would be considered by the Councils, a progress report made to the Assembly in February, and the proposal returned to the Executive Council (with recommendations) in May for possible action at the Assembly meeting in November.

RECOMMENDATION: That the Organization of Student Representatives consider the matter of Faculty Representation in the AAMC and the appropriateness of the mechanism proposed in the attached documents.

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

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

WASHINGTON: 202: 466-5175

December 8, 1971

MEMORANDUM

TO: AAMC Executive Council Members

FROM: Office of the President

SUBJECT: FACULTY REPRESENTATION IN THE AAMC

The enclosed paper on faculty representation in the AAMC was prepared by AAMC staff at the direction of the participants in our December Retreat. The paper summarizes the discussion of the Retreat on this issue, and presents to the Executive Council the recommendations of the Retreat.

This subject will be open to discussion at the December 17th Executive Council meeting.

cc: Dr. Kinney, Mr. Danielson, Mr. Thomas, Dr. Wilson, Dr. Swanson, Mr. Fentress, Mr. Murtaugh

RETREAT DISCUSSION OF FACULTY REPRESENTATION IN THE AAMC

The question of faculty representation served as the focus of discussion at the AAMC's recent Retreat (December 2-4). At issue was the basic justification for such an expansion, the mechanism by which this might best be accomplished, and all long-range implications of such an action on the Association.

Discussion of these questions stimulated a wide range of opinion. While there was general agreement on the value of involvement of the faculties, several questions were raised concerning their role in the governance of the Association. One questioned the possibility of "representation," stating that only the individual delegate would be involved and that nothing would be done to involve or truly represent the whole of the faculty. Another concern was the manageability of the Association: have we reached a critical mass beyond which point proliferation will eventually lead to paralysis.

Extensive debate on these points established a general consensus in favor of formally involving the institutional faculty in both the substance and governance of the Association. As was noted in support of this viewpoint, a primary concern of the AAMC, by definition, is medical education, and this task must eventually be accomplished by the faculty. Seven options for incorporating faculty into the governance of the Association were then solicited:

1) abolish CAS in favor of a Council of Faculties (COF), which would provide for subordinate representation of the professorial societies;

2) retain CAS and establish an Organization of Faculty Representatives (OFR) within the COD--parallel to the OSR;

3) expand CAS to incorporate junior faculty (possible rename COF);

4) establish voluntary compus chapters of the AAMC. Bring a representative of each chapter directly into either CAS or COD. When 50% of the faculties were so organized, they would form a separate council (COF);

5) reorganize regional meetings only, to include COF (Midwest example);

6) retain CAS and establish COF;

Prepared by AAMC for discussion at December 17, 1971 Executive Council meeting.

7) replace COD with a Council of Institutional Representatives (CIR). Each school would have three delegates -- dean, faculty member, student--and one vote.

It was decided that two separate issues had to be resolved: first, how this faculty body is to fit into the AAMC governing structure, and second, how the faculties are to be organized to select a representative.

After much discussion, a consensus was reached on Option #2 above--establishing an Organization of Faculty Representatives under the Council of Deans. An integral part of this consensus was the agreement that this proposal would be presented to and discussed by each of the constituent Councils before going to the Assembly in November. It was also agreed that a moratorium be declared on future expansion of the Association until such time as all the implications of this expansion could be evaluated.

The question of organizing the faculty elicited two different proposals: (1) election of a representative by the whole of the organized faculty (Academic Senate); or (2) establishment of voluntary campus chapters, composed of those faculty members who hold AAMC individual membership and who would elect a representative from their chapter.

While the value of encouraging individual membership was recognized, consensus was reached on the first alternative. The feeling was expressed that the second option would be time-consuming, would leave some schools without faculty representation, and would tend to represent "joiners." It was also described as a "poll tax."

Thus, consensus was reached on an Organization of Faculty Representatives, structurally equivalent to the Organization of Student Representatives, both in its relationship to the governance of the AAMC and in its membership requirements. It was also agreed that AAMC staff would prepare a proposal to transmit this consensus to the December Executive Council meeting for "rigorous debate" and for referral to the February meetings of the CAS, COD, and COTH. A progress report will be presented to the February Assembly meeting, and receipt of the proposal (with amendments and recommendations) from the Councils will be expected at the May 19th meeting of the Executive Council. Final action is aimed at the November Assembly.

This paper and the attached draft Guidelines are therefore submitted to the Executive Council for the review and referral mentioned above.

GUIDELINES FOR THE ORGANIZATION OF FACULTY REPRESENTATIVES

ORGANIZATION

There shall be an Organization of Faculty Representatives which shall be related to the Council of Deans and which shall operate in a manner consistent with Rules and Regulations approved by the Council of Deans.

COMPOSITION

The OFR shall be comprised of one representative form each Institutional Member and Provisional Member of the COD, chosen from the full-time faculty of each such member.

SELECTION

A faculty representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will insure representative faculty input and be appropriate to the governance of the institution. The dean of each participating institution shall file a description of the process of selection with the Chairman of the COD and shall certify to him annually the name of the faculty member so selected.

MEETINGS

Annual Meeting. The OFR shall meet at least once a year at the time and place of the COD Annual Meeting in conjunction with said meeting.

To facilitate the smooth working of the organizational interrelationships, the above shall be interpreted to require that the Annual Meeting of the OFR be held during the period of the Association's Annual Meeting, not simultaneously with the COD meeting. This meeting will be scheduled in advance of the COD meeting at a time which will permit the attendance of interested or designated deans.

ACTIVITIES

The OFR will:

- Elect a Chairman and a Chairman-Elect.
- Recommend to the COD the Organization's representatives to the Assembly. (10% of OFR Membership)
- Consider other matters of particular interest to the faculty of Institutional Members.
- Report all actions taken and recommendations made to the Chairman of the COD.

RELATIONSHIP TO COD

The Chairman and Chairman-Elect of the OFR are invited to attend the COD meetings to make such reports as requested of them by the COD Chairman, to act as resource persons to express the concerns of faculty when invited, and to inform themselves of the concerns of the deans.

RELATIONSHIP TO THE EXECUTIVE COUNCIL

The Chairman of the OFR shall be an ex officio member of the Executive Council with voting rights.

RELATIONSHIP TO THE ASSEMBLY

The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the COD and a number of the OFR equivalent to 10 percent of the members of the Association having representatives in the OFR.

Each such representative (to the Assembly) shall have the privilege of the floor in all discussions and shall be entitled to vote at all meetings.

The Chairman of the Assembly may accept the written statement of the Chairman of the COD reporting the names of individuals who will vote in the Assembly as representatives chosen by the OFR.

COMMITTEES

One representative of the OFR to the Assembly shall be appointed by the Chairman of the Assembly to sit on the Resolutions Committee.

RULES AND REGULATIONS

The OFR shall draw up a set of Rules and Regulations, consistent with these guidelines and the Bylaws of the AAMC, governing its internal organization and procedures. The Rules and Regulations shall be consonant with the goals and objectives of the COD.

FINANCES

- The Association will meet the cost of the travel required for authorized faculty participation in Association committee activities, i.e., Executive Council, Administrative Board, and designated committee meetings.

- Staffing expenses will be allocated by the President by administrative action.
- Other costs associated with faculty participation will have to be individually arranged at the institutional level.
- Association funds required to support this organization must be reallocated from currently budgeted funds reducing activities in other areas.

IX.

CLINICAL CLERKSHIPS FOR AMERICANS FROM FOREIGN MEDICAL SCHOOLS

The Council on Medical Education of the American Medical Association adopted a policy statement on June 23, 1971 (Attachment I), which would permit U.S. citizens who have studied medicine abroad to enter AMA-approved residencies even though they have not fulfilled all the requirements for graduation of the institution they are attending and requirements for licensure in the country of their education (ECFMG prerequisite). As an alternative to fulfilling these requirements, the Council on Medical Education will accept a special junior clinical clerkship provided by U.S. medical schools, separate and distinct from the usual clerkships used by the school for their own students. The Council requires that these students have passed an examination such as Part I of the National Boards, the ECFMG Examination, the FLEX Examination, or a new examination to be devised for this purpose. The most recent AMA guidelines for this clinical clerkship are attached (Attachment II).

The stated purpose of this policy is to allow U.S. citizens to escape the necessity of meeting requirements for assigned social service. This is a particular requirement in Mexico. Students accepted under this policy will not be granted their degree by the foreign school. The U.S. schools accepting these students are also not expected to grant a degree.

The political pressure generated by this enlarging group of American citizens who desire ultimately to practice medicine in the U.S.A. is increasing rapidly. At present we know of three states which have made medical licensure available to American FMG's without regard to ECFMG procedures. (California, New Jersey, and Connecticut - other states are now considering the matter.)

In 1970, approximately 25,000 persons applied for 11,348 entering positions in the medical schools of the U.S.A.

Frequent review of the application-admissions process in a variety of medical schools confirms the logical observation that a large number (possibly several thousand) of adequately qualified applicants are being left over each year. Many of these persons will enroll in foreign medical schools.

The number of qualified "left-over" applicants will likely increase each year for the remainder of this decade if birth crop-applicant ratios continue.

PRIOR ACTION BY THE EXECUTIVE COUNCIL:

On December 16, 1970, the AAMC Executive Council considered

this matter and felt that provision of clinical clerkships for foreign medical graduates was a matter for individual consideration by the individual schools and that no additional Association policy was necessary.

On December 17, 1971, this matter was reconsidered by the Executive Council and was referred to the Council of Deans for its consideration.

EXISTING AAMC PROGRAMS FOR FOREIGN STUDENT TRANSFER:

COTRANS (Coordinated Transfer Application System, beginning 1970) in 1970 matched 82 American FM students with U.S.A. medical schools 39 additional American FM students were transferred on advanced standing outside COTRANS, making a total of 121 transfers.

Data for 1971 is not yet available but applications for COTRANS have increased substantially.

Less than half of the schools of medicine have agreed thus far to participate in COTRANS.

How many spaces are available for transfer on advanced standing in the medical schools of the U.S.A.?

No solid data seems to be available. However, it is estimated that if an aggressive effort were exerted by the schools, a number of these students could be accommodated.

RECOMMENDATION: That the Organization of Student Representatives recommend that the Association adopt the following policy statement:

All U.S. medical schools are urged to pay increased attention to American students in foreign medical schools by being receptive to applicants to transfer on advanced standing via COTRANS, which uses Part I, National Board of Medical Examiners, as a qualifying screen.

Attachment III is a resolution passed by the Midwest-Great Plains Region (COD) on this subject on January 11, 1972.

Attachment IV is a resolution adopted by the Southern Region (COD) on October 10, 1971.

ATTACHMENT I

American Students in Foreign Medical Schools *

The established policy of the American Medical Association with reference to the eligibility of foreign medical graduates for appointment to approved internships or residencies is modified as follows:

1. A new pathway for entrance to AMA approved internship and residency programs, other than those existing under previous AMA policies, is available as of July 1, 1971, for students who have fulfilled the following conditions:

   (a) have completed, in an accredited American College or university, undergraduate premedical work of the quality acceptable for matriculation in an accredited U. S. medical school,

   (b) have studied medicine at a medical school located outside the United States, Puerto Rico, and Canada, but which is recognized by the World Health Organization,

   (c) have completed all of the formal requirements of the foreign medical school except internship and/or social service.

2. Students who have completed the academic curriculum in residence in a foreign medical school and who have fulfilled the above conditions may be offered the opportunity to substitute for an internship required by a foreign medical school, an academic year of supervised clinical training (such as a clinical clerkship or junior internship) prior to entrance into the first year of AMA approved graduate medical education. The supervised clinical training must be under the direction of a medical school approved by the Liaison Committee on Medical Education.

3. Before beginning the supervised clinical training, said students must have their academic records reviewed and approved by the medical schools supervising their clinical training and must pass a screening examination acceptable to the Council on Medical Education, such as Part I of the National Board examinations, or the ECFMG examination, or the FLEX examination.

4. Said students who are judged by the sponsoring medical schools to have completed successfully the supervised clincial training are eligible to enter the first year of AMA approved graduate training programs without completing social service obligations required by the foreign country or obtaining ECFMG certification.

5. The Council on Medical Education will recommend to all state boards of medical examiners that they consider for licensure all candidates who have completed successfully the supervised clinical training on the same basis as they now consider foreign medical candidates who have received ECFMG certification.

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*Policy Statement of the Council on Medical Education
Adopted June 23, 1971

(2) In keeping with the recommendation of the Commission on Foreign Medical Graduates, the clerkship should be one full academic year in duration.

(3) In view of the need for general experience, it is suggested that the clerkship cover several of the more general disciplines. The Mexican "internship" for which this clerkship is intended to be a substitute is comprised of three months each of medicine, surgery, pediatrics, and obstetrics-gynecology.

(4) The clerkship should be under the sponsorship of a U.S. medical school which should have responsibility for the program. It is suggested that these students should not be trained side by side with American medical students since their background is quite different. It is suggested, however, that the training be in a hospital affiliated with the medical school and under the supervision of physicians who hold medical school appointments.

(5) The medical school should have final responsibility for determining the criteria for admission to the program, the characteristics of the program itself, and the evaluation (if any) at the end. The minimum requirement would be for the medical school to certify to the Universidad Autonoma that the student had been in attendance for the full duration of the clerkship.

(6) There must be a screening examination which, combined with evaluation of other credentials, would provide assurance of competence to undertake the clerkship. It is suggested that Part I of the National Board Examination or the first part of Flex might be suitable for this purpose.

(7) It is suggested that it would be highly desirable for the medical school, in addition to providing whatever evaluation it deemed desirable to the Universidad Autonoma and the student, to use an American institution as the central repository for such an evaluation in the event it might prove to be necessary in subsequent years. It was felt that the interest of the United States public might not be fully protected if the student and the Universidad Autonoma were the only custodians of the evaluation.

(8) Recognizing that such a program would require some expenditure of effort or money, or both, by the medical school, it is suggested that the medical school might charge the student an appropriate fee. It is generally agreed, in view of the informal nature of the arrangement between the student and the medical school and the uncertainty regarding legal relationships, that tuition should not be charged without careful consideration of the legal implications.

(9) In order to emphasize the educational nature of the experience for the student and to clearly differentiate the experience from an externship, it is recommended that the hospital not be permitted to remunerate the student and that the student not be permitted to accept any remuneration for his services either from the hospital or from staff physicians.

GRL:kc
4/8/71

Revised
5/26/71
HCN:lwt

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The Midwest-Great Plains Region of the AAMC has reviewed the June 23, 1971 statement of the Council on Medical Education of the AMA which proposed to establish a pathway by which American citizens who are students attending medical colleges outside the U.S. and Canada may enter U.S. programs of graduate education in medicine. (The "Fifth Pathway").

The proposal would establish special clerkships approved by American medical colleges to substitute for required foreign internships. It is noted that such students may enter the special clerkships for the subsequent graduate program without completing the requirements for either the degree or licensure in the nation of their schooling. Therefore, be it moved that this plenary session on the MW-GP Region recommend the following statements in response to the CME proposals:

1. Each member college should develop admissions and evaluation mechanisms which would allow matriculation of the students concerned at undergraduate levels appropriate to their measured knowlege and skills, and leading to the granting of the M.D. degree. Mechanisms could include but not be limited to COTRANS, and would be determined by the member institution. Such programs would supply a graduated, educational response to the measured student capabilities, rather than a rigid, time limited experience that is oriented to a group rather than an individual student.

2. Since the proposed "clerkship" relates principally to matriculants of one foreign medical school who have

not completed the degree requirements of the nation in which that school is located; and since the recommendation above would provide adequate opportunity for those and other students to earn an uncompromised degree: member institutions should look with disfavor on involvement in a program where their responsibility for quality education is diluted. Such dilution and compromise occurs in the proposed "Fifth Pathway" clerkship.

Resolution adopted by the Midwest-Great Plains Region on January 11, 1972.

The Deans of the Southern Region urge that the AAMC make an official policy statement regarding the Council on Medical Education policy with respect to American students in foreign medical schools. The Association is urged to take the position that, not withstanding the implication in the AMA statement, whether or not a school undertakes to provide the year of supervised clinical experience referred to is a matter within the sole discretion of that school.

Resolution adopted by the Southern Region on October 10, 1971

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

REVISED SCHEDULE OF 1972 MEETINGS OF THE GROUP ON STUDENT AFFAIRS (GSA)

DATES	REGION	LOCATION	LOCAL HOST	GSA REGIONAL OFFICERS* CHAIRMAN	VICE-CHAIRMAN	SECRETARY
April 11-13	South	San Antonio Texas	Fred Taylor Texas, San Antonio	E. Croft Long Duke	Robert L. Simmons New Orleans	Thomas W. Johnson Meharry
April 16-18	West	Asilomar Pacific Grove, California	John Wellington U. of Calif., San Francisco	John Wellington U. of Calif., San Francisco	John A. Watson U. of Calif., San Francisco	None
May 4-6	Central	East Lansing Michigan	Daniel Cowan Michigan State U.	Jack M. Colwill U. of Missouri, Columbia	John C. Herweg Washington U., St, Louis	Lloyd Ferguson U. of Chicago, Pritzker
June 20-22	North-east	Burlington Vermont	David Tormey U. of Vermont	Karl Weaver Maryland	Arthur J. Kahn N.J. (Newark)	Mary Ellen Hartmann Med. Coll. of Pa.
November 2-5	AAMC Annual Meeting	Miami Florida	None	Robert L. Tuttle Texas, Houston	Robert A. Green Michigan	Davis G. Johnson AAMC

*Treasurer of the Northeast GSA is William Fleeson, U. of Connecticut.

DGJ/sg 1/17/72

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