AGENDA
FOR
COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

WEDNESDAY, APRIL 9, 1986
6:00 PM - 10:00 PM
HAMILTON ROOM

THURSDAY, APRIL 10, 1986
8:00 AM - 12 NOON
GRANT ROOM

WASHINGTON HILTON HOTEL
WASHINGTON, DC

one dupont circle, n.w./washington, d.c. 20036
FUTURE MEETINGS

CAS Administrative Board Meetings

June 18-19, 1986       Washington Hilton Hotel
September 10-11, 1986  Washington Hilton Hotel

CAS Spring Meeting

March 19-20, 1987       Washington, D.C.

AAMC Annual Meetings

November 7-12, 1987     Washington, D.C.       (CAS meets Nov. 8-9)
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

April 9, 1986

7:00 p.m. CAS Administrative Board Reception
Grant Room

8:00 p.m. CAS Dinner
Hamilton Room

April 10, 1986

8:00 a.m. - 12 noon CAS Administrative Board Meeting
Grant Room

12 Noon - 1:00 p.m. Joint Administrative Boards Luncheon
Hemisphere Room

1:00 p.m. - 3:30 p.m. Executive Council Business Meeting
Military Room
AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD
April 9-10, 1986

I. Report of the Chairman

II. ACTION ITEMS
A. Approval of the Minutes of the January 22-23, 1986 Meeting of the CAS Administrative Board ........................................ Y1
B. Membership Application: American Association of Pathologists ........................................ Y9
C. Report of the Committee on Financing GME ........................................ B19
D. Report of the Ad Hoc Committee on Federal Research Policy ........................................ B102
E. Finance Committee Interim Report ........................................ mailing
F. Proposed Medicare Regulations on Payments for Medical Education ........................................ B171
G. Revision of the General Requirements Section of the Essential of Accredited Residencies ........................................ B18
H. Changes in GME Training Requirements ........................................ B166
I. Tax Report Update ........................................ B169
J. Interpreting the AAMC Policy in the Treatment of Irregularities in Medical School Admissions ........................................ B164

III. DISCUSSION ITEMS
A. Current Proposals on Reimbursement of Indirect Costs .......... B189
B. Medical Malpractice Insurance Legislation ........................................ Y11
C. 1986 CAS Fall Meeting Program ........................................ Y24

IV. INFORMATION ITEMS
A. Graduate Medical Education Committee ........................................ Y25
B. CAS Nominating Committee ........................................ Y27

B = Blue Agenda Book
Y = Yellow Agenda Book
MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 22-23, 1986
Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

David H. Cohen, Chairman
Joe D. Coulter
William F. Ganong
Gary W. Hunninghake
Ernst R. Jaffe
A. Everette James, Jr.
Gordon I. Kaye
Douglas E. Kelly
Jack L. Kostyo
Frank G. Moody
Virginia V. Weldon

Staff

David Baime*
Melissa Brown*
Christine T. Burris
John A. D. Cooper*
Carolyn Demorest
Joseph A. Keyes, Jr.*
David B. Moore
James Schofield*
John F. Sherman*
Elizabeth M. Short
August G. Swanson*
Kathleen Turner*

Guests

Richard Janeway*
Edward J. Stemmler*

* Present for part of meeting

I. The CAS Administrative Board met at 4:30 p.m. Wednesday, January 22, 1986, for an informal discussion of several issues related to representation in the Council of Academic Societies. Dr. Cohen noted that this discussion was prompted, in part, by the continued proliferation of societies seeking membership in the Council and by a growing number of complaints with respect to the representation of societies on the Administrative Board. He said that there were three main questions to be addressed: should the criteria for Council membership be changed, how should member societies be represented within the Council, and how should the members of the Administrative Board be selected?

The general consensus among Board members was that the CAS should be broadly representative of the faculty at academic medical centers; therefore, the criteria for membership should remain relatively open. Two possible dangers were identified with open admission: development of a duplicate constituency and inclusion of non-academic groups. A duplicate representation was thought to be problematic only in terms of the governance of the Council, but because the Council rarely, if ever, takes formal votes on issues, this was not seen as a prohibitive problem. The Board was unable to determine a crisp a priori definition of an academic society for use as an admission criterion; therefore, it was decided that the Board would continue to deal with the question of whether a society is "academic" on a case-by-case basis at the time of the society's application for membership.
With respect to the representation of the individual member societies within the Council, it was felt that the current public affairs and legislative issues facing faculty are inseparable from other academic issues. The Board therefore recommended discontinuation of the office of Public Affairs Representative (PAR). It was decided that each society would continue to have two representatives; however, the Board recommended that the Rules and Regulations should be amended to leave the length of the term for CAS representatives to the discretion of the individual societies. Guidelines would be provided to the societies suggesting that at least one representative have a term sufficient to develop expertise with the issues of importance to the Council and the Association.

It was agreed that the most important consideration in selecting members for the Administrative Board should be the quality of the individuals. As a result, the Board recommended that the current custom of maintaining a 6:6 ratio of basic scientists to clinicians be replaced with a more flexible system with a minimum of 4 basic scientists and 4 clinicians on the Board. This would facilitate the selection of the best possible representative for service on the Board. The Board also recommended an explicit information campaign related to the representation on the Board, and suggested that the CAS Nominating Committee solicit recommendations from the society representatives for nominees for the Board prior to the Committee’s conference call in May.

The meeting was adjourned at 6:20 p.m., at which time the CAS Board joined the COD and COTH Boards for a reception and dinner to honor Carolyne K. Davis, Ph.D., former administrator of the Health Care Financing Administration.

II. BUSINESS MEETING

A. ACTION ITEMS

1. Approval of Minutes

The minutes of the September 11-12, 1985 meeting of the CAS Administrative Board were approved as submitted.

2. Appointment of the 1986 CAS Nominating Committee

The CAS Administrative Board appointed the following individuals to the CAS Nominating Committee:

Chair: Frank G. Moody, M.D., Society of Surgical Chairmen
Basic Scientists:
   David H. Cohen, Ph.D., Society for Neuroscience
   Rolla Hill, M.D., Association of Pathology Chairmen
   Mary Lou Pardue, Ph.D., American Society for Cell Biology
Clinical Scientists:
   Jerry Wiener, M.D., American Association of Chairmen of Departments of Psychiatry
   Nicholas Zervas, M.D., American Association of Neurological Surgeons
   Jo Anne Brasel, M.D., Endocrine Society
Alternates for Basic Scientists:
Leonard Share, Ph.D., Association of Chairmen of Departments of Physiology
John Basmajian, Ph.D., American Association of Anatomists

Alternates for Clinical Scientists:
C. Philip Larson, Jr., M.D., Association of University Anesthetists
Jerome Goldstein, M.D., Society of University Otolaryngologists-Head and Neck Surgeons
Edwin Cadman, M.D., American Federation for Clinical Research

Dr. Moody, as chairman of the CAS Nominating Committee, will represent the CAS on the AAMC Nominating Committee.

3. Dr. Cohen welcomed the new members of the CAS Administrative Board -- Joe D. Coulter, Ph.D., Society for Neuroscience, Gary Hunninghake, M.D., American Federation for Clinical Research; Gordon Kaye, Ph.D., Association of Anatomy Chairmen; and Ernst Jaffe, M.D., American Society of Hematology.

4. Membership Application

Drs. Kostyo and Yatsu recommended that the Association for Surgical Education be admitted to membership in the Council.

ACTION: The CAS Administrative Board voted to approve the application of the Association for Surgical Education for membership in the CAS and to forward this application to the Executive Council.

5. Request by the American College of Legal Medicine to Reapply for Membership in the Council of Academic Societies

After thorough discussion at several Administrative Board meetings, the original application of the ACLM was rejected in a letter dated 9/27/82 to the president of the ACLM, on the grounds of both insufficient faculty representation among the membership and the society’s emphasis on medical practice issues rather than medical education. In December 1985 the ACLM announced by letter its intention to reapply for membership, based primarily on a typographical error in another society’s application.

In discussion of the ACLM request, the Administrative Board emphasized that the primary requirements for membership in the Council of Academic Societies, namely an emphasis on medical education and research, particularly as they occur within the academic medical center, had not changed. In view of this primary requirement, the Administrative Board agreed that a reapplication by the ACLM would probably be refused on the same grounds as the initial application. It was agreed that a letter discouraging but not refusing reapplication should be sent to the ACLM.
ACTION: The CAS Administrative Board voted to send a letter to the American College of Legal Medicine discouraging their reapplication to the CAS on the grounds that the society fails to meet the membership criteria of medical education in medical schools.

6. LCME Involvement in the Accreditation of Foreign Medical Schools

Joe Keyes from the AAMC staff reviewed the discussion by the COD Administrative Board on this issue. The COD requested that the recommendation be stated in a more positive manner, recognizing the serious nature of the issue and suggesting that the Association work with the AMA and other organizations in finding solutions to the problem. The COD also recommended that the Association remain silent on whether the LCME should accept responsibility for the accreditation of foreign medical schools. Mr. Keyes noted that the COD Board was in general agreement on the issue of refusing the LCME permission to accredit foreign medical schools for both legal and financial reasons.

James Schofield, who serves as executive secretary for the LCME, expressed his concern with the effect of state licensure laws on the curricula in medical schools. He predicted that the pressure on the individual state licensure boards to deal with the problem of foreign medical graduates will result in the passage of more restrictions, which will, in turn, place more demands on the curriculum. Dr. Schofield is not as concerned with whether the LCME becomes involved in the inspection of foreign medical schools. He did suggest, however, that if nothing happens on this issue, the federal government might become involved in inspecting foreign medical schools. This inspection might be then extended to domestic medical schools.

Mr. Keyes explained the four specific positions that the Board had been requested to reaffirm. The first was opposition to the use of Medicare funds to pay for the graduate medical education expenses of foreign medical graduates. The second was support for an amendment to the Higher Education Renewal Act that would require a foreign medical school to enroll at least 75 percent of its student body from the citizenry of the country where the school is located for its students to be eligible for guaranteed student loans. The third position was support for an examination of clinical competence for foreign medical graduates to enter into accredited graduate medical education programs. The fourth position was to support a requirement that foreign medical graduates must pass both parts of the FMGEMS examination at the same administration.

ACTION: The CAS Administrative Board voted unanimously to reaffirm the four positions recommended by staff. The Board also voted unanimously to approve the COD's request for a recommendation, phrased in general terms, that this issue be discussed with the AMA and other agencies.
7. Tax Reform Act

John A. D. Cooper, M.D., Ph.D., president of the AAMC, John Sherman, Ph.D., vice president of the AAMC, Virginia Weldon, M.D., chairman of the AAMC, and Richard Janeway, M.D., immediate past chairman of the AAMC, visited the CAS Board to discuss various proposed policy positions with regard to the Tax Reform Act of 1985 (H.R. 3838). Dr. Sherman explained that this legislation contains three components of major interest to the Association: access to capital under tax-exempt bonds, taxation of scholarships, and retirement benefits.

With regard to tax-exempt bonds, the Board agreed that the AAMC should lobby to have all 501(c)(3) organizations excluded from all restrictions on the use of tax-exempt bonds. As a fallback position, the Board agreed that the AAMC should lobby for a modified version of the bill that would eliminate a proposed cap on the amount of bonds each state can issue per year, but would permit other restrictions.

The Board also agreed that it is appropriate for the Association to take the lead in opposing the enactment of taxation on scholarships and fellowships. The Board also agreed that the staff recommended positions on retirement benefits were appropriate and should be approved.

**ACTION:** The CAS Administrative Board voted unanimously to approve the staff recommended positions on this bill.

8. Deficit Reduction

Dr. Sherman explained the three general policies recommended by staff to deal with developments surrounding attempts to reduce the federal budget deficit. The CAS Board discussed whether the Association should take a lead in advocating "whatever tax increases are needed to operate and manage important national programs efficiently and economically."

**ACTION:** The CAS Administrative Board voted unanimously to endorse the Association's leadership in advocating revenue enhancement.

The Board discussed the current situation with regard to Medicare Part A, particularly that as a result of a recent tax increase, current receipts exceed disbursements, and that this program has been subjected to substantial reductions in expenditures over the last 5 years.

**ACTION:** The CAS Administrative Board voted unanimously to endorse the Association's support for an amendment of the Gramm-Rudman-Hollings law to protect Medicare Part A from further reductions in outlays.

The Board also discussed the extensive proposals to modify the Medicare legislation contained within the fiscal 1986 budget reconciliation package.
 ACTION: The CAS Administrative Board voted unanimously to endorse the positions recommended by staff related to the Medicare legislation.

9. Report of the Steering Committee on the Evaluation of Medical Information Science in Medical Education

Dr. Jack Myers, chairman of the Steering Committee, reviewed the background on medical informatics, which concerns the organization and management of information in support of medical research, education, and patient care. Dr. Myers explained the Steering Committee's two fundamental recommendations: that medical informatics should become an integral part of the medical school curriculum and that it have a definable locus within the medical school. How this is accomplished would be left to the individual institutions. He noted that the Steering Committee also recommended a series of coordinated actions involving the Association, the National Library of Medicine, and the NIH.

The CAS Board discussed at length the recommendation that medical informatics become an integral part of the curriculum. Concern was expressed that this recommendation might be interpreted as calling for coursework on informatics, rather than focusing on the use of computers in the educational process.

Dr. Cohen expressed the Board's appreciation to Kat Turner for her work on this project. The Board commended the report in general for providing substantial information on medical informatics.

ACTION: By a vote of 6-4, the CAS Administrative Board approved the recommendation that the Executive Council accept the report and distribute it. The Board further instructed the CAS representatives to the Executive Council to express the Board's reservations with the wording of the recommendation that informatics become an integral part of the medical curriculum.

10. Malpractice Insurance Legislation

Nancy Seline from the AAMC staff, described the background for the current malpractice insurance legislation (S. 1804 and H.R. 3865) that would establish a federal incentive grant program for states that reform their laws governing malpractice insurance. This law would encourage states to modify tort laws to limit the size of the legal fees associated with these cases and to limit the size of the non-economic damages awarded in these cases. She noted that these two factors are often cited as the primary causes for the dramatic increase in malpractice insurance cost.

The CAS Board discussed the role that the Association should play in relation to the AMA, which was the force behind the introduction of this legislation. It is uncertain how far this legislation will move, but HHS Secretary Bowen has identified
malpractice as a major issue. The Board generally agreed that the Association should support the AMA, but should reserve the right to speak out on issues that are of particular interest to the academic medical centers, such as the use of trainees, the acuity of illness of patients seen in these institutions, the experimental nature of some of the treatments provided, and the dependence on the revenue going beyond practice to the entire medical center to support items of societal benefit.

ACTION: The CAS Administrative Board voted unanimously that the Association position itself in support of the AMA with regard to the malpractice insurance legislation, but that we should reserve the right to speak out on issues that are of particular concern to academic medical centers. The Board also requested more information on this issue to help identify the unique vulnerabilities of academic medicine.

11. Ad Hoc Committee on Graduate Medical Education

In September 1985, the Executive Council authorized the appointment of an ad hoc committee charged to consider the problems created by the residency selection process. During discussion of this issue at the Officers' Retreat in December, it was generally agreed that the transition problems cannot be isolated from overall graduate medical education issues. Thus, it was recommended that the ad hoc committee should review the Association's past positions relative to graduate medical education and recommend both short term and long range strategies to improve graduate medical education and achieve a rational continuum between medical school and residency training.

The CAS Board discussed the concern raised by the COD that this broader charge might sidestep some of the initial questions raised in regard to the fourth year of medical school and the transition to residency training. The Board also discussed the COD's recommendation that the charge to the committee should be more specific and that the committee should address the issue of the fourth year first.

ACTION: The CAS Administrative Board voted unanimously to approve the recommendation for an ad hoc committee on graduate medical education, and that this committee should address the problems associated with the fourth year and the transition to residency training.

12. Coordinated Medical Student Loan Program

Staff presented a proposal for an alternative loan program for medical students. The Association would enter into a contract with a national lending institution, which will be selected on the basis of competitive bidding, and the Higher Education Assistance Foundation (HEAF), which will act as loan guarantor for most of the specific loan programs used by medical students.
The program offers both financial and administrative advantages for students. The principal advantage would be to streamline the application process. Students would use a single application process for four federal loan programs, including CSL and HEAL. This program would guarantee access to loans for all medical students, and also would provide consolidation and flexible repayment and interest options.

The Association’s involvement would be limited to the application process itself. HEAF would use the AAMC data base to verify student’s position in medical school. The AAMC would ge additional information on student indebtedness. The financial aid officers at the medical schools and the student representatives approve of this proposal. Staff would like to implement it for 1986.

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council authorize staff to proceed with the development of the Coordinated Medical Student Loan program.

B. Information Items

1. Incorporation of ACCME

The CAS Board discussed the advisability of incorporating the ACCME for the purpose of limiting the potential liability of the parent or sponsor institutions. This discussion was stimulated by a recent suit against the ACCME. It has become evident that the parent bodies could be sued for accreditation decisions in which the parent bodies are not involved because the parent bodies do establish the standards for accreditation. It would appear that the liability of the sponsoring organizations may be limited in almost direct proportion to the degree of autonomy that results from the incorporation. For example, if the sponsoring organizations retain the authority to appoint members of the governing board or to approve changes in accreditation standards, they also would retain the liability with respect to challenges based on those standards.

The Board agreed that the objective of isolating the parent organizations from financial liability is sufficiently important to warrant relinquishing some control. The Board also agreed that any action in this matter should not be viewed as a precedent for the LCME or other organizations with which the Association may wish to maintain a sponsor or parent relationship.

2. 1986 CAS Spring Meeting

The CAS Board reviewed plans for the Spring Meeting, which will include discussions of faculty practice and federal biomedical research policy during Wednesday’s plenary session.
MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Mr. David Moore

NAME OF SOCIETY: American Association of Pathologists, Inc.

MAILING ADDRESS: 9650 Rockville Pike
Bethesda, MD 20814

PURPOSE: The purpose of the Association is the advancement and dissemination of knowledge of disease by scientific and educational means.

MEMBERSHIP CRITERIA: Any American investigator who has contributed meritorious work in pathology is eligible for active membership.

NUMBER OF MEMBERS: 2500

NUMBER OF FACULTY MEMBERS: Approximately 90 percent.

DATE ORGANIZED: Founded December 1900; reincorporated July 1, 1976

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

 Adopted 1976
 Revised 1979

April 21-26, 1985

1. Constitution & Bylaws

2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)
QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

   X YES  NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

   501(c)(3)

3. If request for exemption has been made, what is its current status?

   X a. Approved by IRS
   _ b. Denied by IRS
   _ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

   (Completed by - please sign)

   February 10, 1986
   (Date)
MALPRACTICE INSURANCE LEGISLATION

The high cost of malpractice insurance has become a major issue for hospitals and practicing physicians. Some physicians have stopped or restricted their practice to limit malpractice liability. Hospitals and physician groups have employed various strategies to reduce the cost of insurance, including the creation of their own insurance companies or insurance pools. Still, the expense for this insurance is rising rapidly. One reason cited for the increase in premium expense is the size of the awards granted. Another is the frequency with which suits are filed because it is a lucrative business for attorneys.

Hatch Bill (S. 1804)

To curb the cost of malpractice insurance, Senator Hatch (R-UT) and Congressman Lent (R-NY) have introduced a bill (S. 1804 in the Senate, H.R. 3865 in the House) that would establish a federal incentive grant program for states that reformed their laws governing malpractice insurance to:

- allow installment payments of awards in excess of $100,000;
- require that the award to an individual be offset by any other payments made to compensate for the injury, including disability insurance and private health insurance payments;
- prohibit awards for non-economic damages, such as pain and inconvenience, from exceeding $250,000;
- establish a fee schedule for attorneys that would allow attorneys to collect -
  no more than 40 percent of the award if the settlement or award is $50,000 or less;
  $20,000 plus a third of the amount awarded over $50,000 if the settlement or award is more than $50,000 but less than $100,000;
  $36,667 plus 25 percent of the amount awarded in excess of $100,000 if the award or settlement is more than $100,000 but less than $200,000; and
  $61,667 plus 10 percent of the amount awarded in excess of $200,000 if the award or settlement is more than $200,000.
- allocate an amount equal to the licensing or certification fees of each type of health care professional to the state agency responsible for the conduct of disciplinary action for such health professionals;
- require each health care provider to have a risk management program;
require each professional liability insurer in the state to make available to licensing boards data on settlement, judgments, and arbitration awards and to establish risk management programs that must be attended once every three years by any professional seeking malpractice insurance; and

authorize state agencies to enter into agreements with professional societies to review malpractice actions or complaints against a health care professional.

Qualifying states would be eligible for a development grant of $250,000 to plan and implement these necessary legislative reforms. Once the reforms are in place, the state would be eligible for incentive grants of $2,000,000 that could be used to study professional liability programs or to augment state health programs.

The AMA has been the force behind the introduction of this bill and has asked if the AAMC wishes to join in its efforts to muster support for the legislation. The cost of malpractice insurance is a major concern for academic medical centers, especially if it forces physicians to limit the cases seen or treatments performed. Such limits could mean that residents being trained in some specialties or subspecialties may not be exposed to the full scope of patients normally treated by practitioners in that field. Additionally, teaching hospital emergency rooms could become the treatment sources for patients who are difficult to treat and, therefore, more likely candidates for malpractice claims. Thus, it is important for the AAMC to consider options for addressing the malpractice issue.

Critics of the proposed federal legislation suggest that:

- The bill may appear self-serving for the medical community because it places a limit on the "non-economic" damages that is considerably below the amount of some awards.

- One of the functions of the current tort law system is that it places a financial penalty on those who fail to meet the standard of care required of them. To the extent that the penalty is being ameliorated, some would argue that there is a need for a different type of assurance that quality care will be rendered. For example, some might suggest that a physician whose practice is found negligent should be required to attend some educational session analogous to a driver education program.

- Insurance is a matter within the jurisdiction of the state governments, not the federal government; therefore, more appropriate reforms could be achieved by working directly with state legislatures to enact reforms.

At the January 21, 1986 meeting of the Executive Council there was discussion of the features of the malpractice problem that were unique to the academic setting, including the mobility of faculty and the use of part-time faculty.
There was also a discussion of the need for the profession to improve disciplinary procedures. Finally, there was a realization that large awards associated with liability judgments have jeopardized forms of liability insurance beyond medical malpractice.

Although there was general support for the bill, there was some concern about the provisions relating to the attorney fee schedule and some questions about the bill's constitutionality. It was decided that the Association would support the bill in its overall thrust, particularly stressing the areas of concern to academic medical centers, and would work with the AMA to achieve tort reform.

**Durenberger Bill (S. 1960)**

Recently, Senator Durenberger (R-MN) and Congressman Moore (R-LA) introduced a medical malpractice bill (S. 1960, H.R. 3084) to encourage voluntary settlement of personal injury claims under Medicare, Medicaid, CHAMPUS and other federal programs. The legislation provides a model system to be adopted by the states. If states do not implement it, it would be implemented at a federal level. Key provisions include:

- **tender of compensation** - if a potentially liable physician provides the injured patient with a written tender to pay compensation benefits for the injury as specified in this bill, the injured individual would be foreclosed from later bringing suit. If a tender is not offered within 180 days, the injured individual may request arbitration and the arbitrator will decide the degree of liability of the doctor.

- **amount of compensation** - would equal only economic loss as defined in the bill, plus attorneys fees. Non-economic loss, such as pain and suffering, would not be compensated.

- **payment schedule** - compensation would be paid within 30 days of each legitimate bill to a maximum period of 5 years, but could be paid in equivalent medical services when appropriate. A lump sum payment settlement could be negotiated at any time, but if the economic loss exceeded $5,000, the settlement would require court approval.

- **M.D.s could not participate** in this alternative liability program without professional malpractice insurance or suitable other indemnity.

The AAMC Executive Council has not yet considered our Association position on the Durenberger bill.
CONGRESSIONAL RECORD—SENATE

By Mr. HATCH (for himself, Mr. ANDERSON, and Mr. ISHII):
S. 1804. A bill to provide for Federal incentive grants to encourage state health care professional liability reform; to the Committee on Labor and Human Resources.

GENERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT

Mr. HATCH. Mr. President, I send to the desk the "Federal Incentives for State Health Care Professional Liability Reform Act of 1985." This bill addresses a growing problem in maintaining a wide range of affordable health care services for the American people. I am talking about the problem of soaring medical malpractice costs and the resulting increased expense, and sometime unavailability, of medical professional liability insurance.

Last year, the Labor and Human Resources Committee held hearings which revealed the extent of this problem and the threat it poses to our health care system. In many areas, premiums for professional liability insurance for physicians continue to rise 20, 30, 40 percent a year and more.

The crisis is particularly acute for those rendering obstetrical care. In Florida, 20 percent of obstetricians have reportedly stopped delivering babies and now limit their practice to surgery. In North Carolina, family physicians' malpractice insurance for obstetrics just increased 400 percent, and the majority are reported to be stopping delivering babies.

Nur is the problem confined to physicians. Nurse-midwives, though traditionally at considerable lower risk of suit than physicians, are sometimes categorized with them by insurance companies for premium purposes. In many States, nurse-midwives have recently been unable to obtain insurance, or can obtain it only at exorbitant rates which put it beyond the reach of their incomes. The consequences of such trends among health professionals are obvious—access to health care may be seriously jeopardized unless a prescription is written to treat this malpractice fever.

State governments should bear the responsibility of defining the judicial or administrative system governing recovery for malpractice injuries, and they are not blind to the medical professional liability insurance crisis. All but one State have at least begun to act on their negligence or tort law systems, and many of them are considering further steps. Among these are submission of claims to arbitration panels, limitations on attorney's contingency fees, modification of the collateral source rule, limits on recoverable damages, the establishment of a patient compensation fund, the requirement of periodic payment of large awards, the establishment of pretrial screening panels, and shortening the statute of limitations.

Many of these represent worthwhile improvements. By and large, they respond to perceived failings in the current tort law system, such as the ability of skillful attorneys to obtain exaggerated judgments for pain and suffering, the inducement to unwarranted litigation afforded by an escalating contingency fee schedule for attorneys, and the slowness of the legal system in delivering compensation to the injured. Studies have shown that different reforms have different abilities to achieve the overall goal of reducing the total costs of medical malpractice litigation, and thus of liability insurance, and more efficiently delivering compensation.

The legislation I am introducing today sets up monetary incentives to encourage States to adopt further administrative improvements and four tort law reforms, three of which have been found to be among the most effective in holding down litigation costs. This represents a refined version of a proposal drafted by the American Medical Association, and will serve to move the debate on malpractice insurance forward into the consideration of specific legislative solutions.

Briefly, this proposal would fund development grants by which States would design and implement a strategy leading to adoption of these reforms. Additionally, it would grant $2 million the first year and $1 million per year for the next 2 years to any State which adopts all the recommended measures. This money could be used for a broad variety of public health programs, or to conduct studies of the professional liability problem specific to that State.

The reforms named in the bill are:

First, periodic payment of damage awards over $100,000; second, elimination of the collateral source rule, thus providing for the reduction of awards by amounts received from other sources for the same injury; third, limitation of non-economic damages (pain and suffering) to $250,000; fourth, limitation of attorney's contingency fees; fifth, allocation of an amount equivalent to that collected from physicians' licensing fees to the State agency responsible for disciplinary actions; sixth, requirement that hospitals develop risk management programs and require physician participation as a condition to receipt of insurance; seventh, requirement that insurance companies make certain data available to State agencies; and eighth, provision for increased peer review by State medical societies of questionable practice patterns.

I believe that some of these proposals strengthen the ability and resources of State boards entrusted with the duty
October 28, 1985
CONGRESSIONAL RECORD — SENATE

October 28, 1985

The insurance problem is a serious one. The increase in liability costs and insurance premiums not only threatens access to care in many fields, it leads directly to the practice of defensive medicine, in which health professionals not for greater frequency of health care testing and services, but for fear of malpractice suits and the cost resulting from professional liability, including premiums for professional liability insurance. The American Medical Association has provided us with a thoughtful, useful discussion piece. I challenge the test in this situation. And the problem is not done so, it has itself to blame for the current situation.

However, claims are also skyrocketing among health professionals who are skilled and conscientious. Part of this may result from the increase in the variety of medical technology and services; from higher, sometimes unrealistic, public expectations of what medicine can do; from a new readiness of the ordinary citizen to sue other medical practitioners, patients and attorneys willing to file suits that may be marginal or unfounded, hopeful of huge awards or settlements. It is to address some of these problems that I am introducing the bill. I am advocating the bill. The bill's reforms would bring down the cost of medical litigation and would result in a higher level of competence among health professionals.

The current "mists" may be less realized, but when they have gone into effect, the current "crisis" may be less evident.

This leads to another issue: The most recent information available to me indicates that one or another of the listed provisions has been invalidated under state constitutions in five States. Since it would certainly not be our intent to bring about the defeat of some grand Federal design. Those doubts persist here. Further, I note again that many of these reforms have already been considered and some adopted, by a number of States. The benefit from the reforms is yet to be realized, but when they have gone into effect, the current "crisis" may be less evident.

Regardless, the insurance problem is a serious one. The increase in liability costs and insurance premiums not only threatens access to care in many fields, it leads directly to the practice of defensive medicine, in which health professionals not for greater frequency of health care testing and services, but for fear of malpractice suits and the cost resulting from professional liability, including premiums for professional liability insurance. The American Medical Association has provided us with a thoughtful, useful discussion piece. I challenge the test in this situation. And the problem is not done so, it has itself to blame for the current situation.

However, claims are also skyrocketing among health professionals who are skilled and conscientious. Part of this may result from the increase in the variety of medical technology and services; from higher, sometimes unrealistic, public expectations of what medicine can do; from a new readiness of the ordinary citizen to sue other medical practitioners, patients and attorneys willing to file suits that may be marginal or unfounded, hopeful of huge awards or settlements. It is to address some of these problems that I am introducing the bill. I am advocating the bill. The bill's reforms would bring down the cost of medical litigation and would result in a higher level of competence among health professionals.

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INCENTIVE GRANTS

Sec. 5. (a) A State may submit an application to the Secretary for a grant under subsection (b) if the application demonstrates—

(1) written enforcement actions against companies in the State in the past three years sufficient to show that the State has adopted or enacted the State liability reforms described in section 6.

(2) the certification of the Attorney General of the State that the State has adopted or enacted the State liability reforms described in section 6.

(3) that the amount of a grant under paragraph (1) is less than $5,000,000, the amount of the grant under subsection (b)(3) shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(c)(1) by $5,000,000, except as provided in paragraph (3)(A) and subsection (d) of section 6.

(b) A grant received by a State under this section may not be used by such State to satisfy any provision of Federal law which requires that, in order to qualify for Federal assistance under such law, the State pay a portion of the costs of the project, program, or activity to be conducted with such Federal assistance.

STATE LIABILITY REFORMS

Sec. 6. (a) The State liability reforms which shall be developed with a grant under subsection 4, which shall be enacted, adopted, or be in effect in a State in order for the State to receive a grant under section 8(b)(3), and which shall be in effect in a State in order for the State to receive grants under section 8(c)(2), are the reforms specified in subsections (b) through (f) of this section.

(b) A State shall require, that in any legal action for damages resulting from such practice, which shall be calculated at the State in order for the State to receive grants under section 8(c)(1).
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annual rate at which such damages were calculated under such schedule; and

(c) The court shall require that all such periodic payments be made through the establishment of a trust fund or the purchase of annuities for the beneficiaries for the continuance of the claimant or for the continuance of the claimant's dependents.

(c)(1) A State shall require that, in any legal action for damages for malpractice in which a claimant or a beneficiary has not yet been harmed by another person, the claimant or the beneficiary shall be made to be paid by any other person, the claimant or the beneficiary shall be made to be paid by any other person who has been made by the court to be paid by such individual and/or the court to be paid by such individual, in any legal action for damages for malpractice in which any of the foregoing has been made or which will be paid by the court to an individual to compensate such individual for injuries sustained as a result of such malpractice, including payments under—

(A) Federal or State disability or sickness programs;
(B) Federal, State, or private health insurance programs;
(C) Employer wage continuation programs; and
(D) Any other source of payment intended to compensate such individual for such injury.

(2) The amount of any award of damages for malpractice which a State shall require such professional to have in effect, or for the continuance of the claimant or for the continuance of the claimant's dependents, shall be an amount equal to the difference between—

(A) the total amount of payments (other than payments received in settlement of such claim) which have been made or which will be made to such individual to compensate such individual for injuries sustained as a result of such malpractice, including payments under—

(A) Federal or State disability or sickness programs;
(B) Federal, State, or private health insurance programs;
(C) Employer wage continuation programs; and
(D) Any other source of payment intended to compensate such individual for such injury,
minus

(A) the amount paid by such individual (or by the spouse or parent of such individual) to secure the payments described in subparagraph (A).

(3) A State shall not require that, in any legal action for damages for malpractice, the amount of any award of damages for noneconomic losses resulting from such malpractice shall not exceed $250,000. For purposes of this subsection, the term “noneconomic losses” means losses for pain, suffering, inconvenience, physical impairment, disfigurement, and other noneconomic losses.

(4)(A) Except as provided in paragraph (2), a State shall require that in any legal action for damages for malpractice in which an individual receives a settlement or an award of damages, the amount of any award of damages for noneconomic losses resulting from such malpractice shall not exceed $250,000. A State shall not permit such individual’s attorney to be in accordance with the following:

If the total settlement or award of damages is not more than $50,000... 40% of such amount:

Not more than $50,000... 40% of such amount:
More than $50,000 but $100,000... 35% of the amount:
More than $100,000 but $200,000... 30% of the amount:
$200,000 or more... 26% of the amount:

(5) A State shall not require that in any legal action for damages for malpractice, the court shall require that an attorney representing the individual shall be paid an amount of fees in excess of the amount specified by paragraph (4) if the court determines that the attorney has added evidence justifying such additional fees.

(6)(A) Each State shall provide for the allocation of the total amount of fees paid to the State in each year for the licensing or certification of each type of health care professional, or an amount equal to such amount, to the State agency or agencies responsible for the conduct of disciplinary actions with respect to such type of professional.

(b) The State shall require each health care provider to have in effect a risk management program which complies with the laws of the State and which is acceptable to the Secretary of Health and Human Services.

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(e)(1) The State shall require that, in any legal action for damages for malpractice in which any of the following has been made or which will be made to such individual to compensate such individual for injuries sustained as a result of such malpractice, including payments under—

(A) Federal or State disability or sickness programs;
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By Mr. DURENBERGER (for himself and Mr. DANFORTH): S. 1960. A bill entitled the "Medical Offer and Recovery Act"; to the Committee on Finance.

MEDICAL OFFER AND RECOVERY ACT

- Mr. DURENBERGER. Mr. President, today I am introducing the Medical Offer and Recovery Act along with my distinguished colleague, the Senator from Missouri (Mr. Danforth). I am introducing this bill as a courtesy to my distinguished House colleagues, Representatives Moors and Gephardt. It is a companion bill to H.R. 3084 which would propose to reform this country's medical malpractice system.

This measure includes refinements to the proposal which they introduced last year and I am including a summary of the bill after my statement which outlines the provisions and changes from last year's version.

My House colleagues spent considerable time and effort developing this proposal and it is a serious contribution to a much needed national debate.

It is the one major measure that provides an alternative to State tort reform, and therefore deserves examination and scrutiny in the Senate.

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along with another important measure, S. 1804, introduced by my distinguished Senate colleague, Orrin G. Hatch. His proposal is authored by the American Medical Association.

Mr. President, there is no question that the funding of malpractice insurance is reaching a crisis point. I was reading an article in the Mankato Free Press from my own State of Minnesota about a young woman named Ann McCall, who was looking forward to having the doctor who had delivered her 21 years before also deliver her new baby. Just 2 weeks before the anticipated delivery date, her doctor informed her that he was turning over his obstetric practice to another doctor because he could no longer afford the escalating cost of his medical malpractice insurance premiums. Zachary McCall was born to Ann and Pat McCall with the assistance of a physician they had known for only 2 weeks.

This story is repeated each day all over this country. And it's happening because there are major problems with the medical malpractice system in the United States.

Malpractice insurance premium costs are skyrocketing, reaching as high as $100,000 a year for some specialty physicians in certain areas of the country. The number of malpractice claims has tripled over the past decade and million dollar settlements happen on a regular basis. The average settlement has grown from $5,000 to over $300,000 in just 6 years.

Growing numbers of claims have resulted in physicians practicing defensive medicine. The AMA estimates that this may cost Americans at least $15 billion a year in extra costs. Still the number of claims against doctors continues to grow, and the public pays for it through high hospital bills, doctor bills, and health insurance premiums.

Higher malpractice insurance costs force doctors and hospitals to raise their charges and pass these costs on to third party payers and consumers.

It is also pricing some physicians out of business. The Minnesota Medical Association estimates that 40 family practice doctors have stopped delivering babies and more are expected to drop the obstetric part of their practice. This could create serious problems for residents in rural Minnesota and similar areas around the country who rely on their community doctor for all their medical care.

The litigation of malpractice cases is unweildy and expensive. It is also time-consuming and inequitable. A few plaintiffs are awarded large recoveries but only after a long, drawn out litigation process. But the real tragedy is that the expense of litigation discourages many with valid claims from even prosecuting those claims. And insurance companies are threatening to quit reinsuring American medical malpractice insurance companies.

These reinsurers are concerned that this may cost Americans at least $30 billion in just 6 years.

These problems are not new. In the mid-1970's, in response to increased numbers of claims and sizes of settlements, insurance carriers were left out of the market and others had to raise their premiums by as much as 400 percent. The States responded to this by enacting medical malpractice before legislation. But these reforms have obviously not had much of an impact.

States are now taking even more steps to reform their tort laws. I was in Florida this year, which learned about their newly passed law which includes a sliding fee scale for attorneys' contingency fees. States are trying the reforms of reform, and the jury is still out on the likely success of these measures. We will watch these changes closely. But it is time to determine whether a Federal role in this area is appropriate.

The crisis may be upon us again. This demands action. We must bring down the cost of medical malpractice insurance to physicians, insurers, and the public, and at the same time, create a fair, equitable, efficient system to adjudicate malpractice. At a time when the health care marketplace is becoming more and more cost-conscious.

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I trust the new year will bring serious debate and resolution of the professional liability crisis. I intend to be at the center of that debate. Mr. President, I ask unanimous consent that the bill and summary of the Medical Offer and Recovery Act be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1960. Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE

This Act may be cited as the "Medical Offer and Recovery Act".

(4) MANIPULATION—Part A of title XVIII of the Social Security Act is amended—

(1) by inserting after the heading to part A the following new subpart heading:

"Subpart I—Hospital Insurance Program"; and

(2) by adding at the end of the following new subpart:

"Subpart II—Alternative Liability System for Malpractice";

"A. DISADVANTAGE BENEFITS IN SETTLEMENT OF MALPRACTICE CLAIMS.

SEC. 1821. (a)(1)(A) In the case of a health care provider (as defined in paragraph (4)(D)(i) which—

(i) is potentially liable for a personal injury (as defined in paragraph (4)(A)) to an injured individual,
If the provider provides the individual not later than the date specified in subparagraph (A) the tender to pay compensation benefits with respect to such injury in accordance with this subpart, the individual and any other entity shall (except as provided in paragraph (B)) be foreclosed from bringing any civil action described in subparagraph (B) against such provider or other entity joined under subsection (b) based on such personal injury.

If the provider fails to provide an individual with such a written tender on a timely basis with respect to a personal injury, the individual may, during the 90-day period beginning on the date specified in subparagraph (C), serve on the provider a written request for arbitration on the question of the legal liability for the personal injury and the provisions of this section shall apply as though a tender under subparagraph (A) had been made. If the arbitrator determines that the provider was wholly or partly legally liable for the personal injury:

(i) the amount of the liability of the provider shall be determined as though the provider made a timely tender under subparagraph (A), and

(ii) the provider shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.

The date referred to in subparagraph (B) is:

(i) in the case of a personal injury resulting from an act or omission in an institution, 180 days after the date of the patient's discharge from the institution;

(ii) in the case of a violation of a federal statute, rule or regulation, a state statute, rule or regulation, or a state law, 180 days after the date of the filing of a claim under such statute, rule or regulation; and

(iii) in the case of any other personal injury, 180 days after the date of the action or inaction giving rise to the personal injury, except that such date may be extended for up to an additional 60 days for purposes of subparagraph (A) if the provider and the patient agree in writing to such extension.

Nothing in this subsection shall be construed as changing any applicable statute of limitations of any State or of the United States.

(2) Except as provided in subparagraph (B), civil actions referred to in paragraph (1) may be brought by any injured individual or any other entity if the provider fails to provide an individual with such a written tender on a timely basis with respect to a personal injury, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that (i) may be a basis for an award of damages for personal injury.

(3) Civil actions referred to in subparagraph (B) do not include:

(i) any action to recover for compensation benefits tendered under this subpart, or

(ii) any action in the nature of a wrongful death action, but only in the case of such an action for losses accruing to survivors after the death of an injured individual and resulting from the death of the individual.

(4) In no event shall a civil action be brought against a compensation obligor other than the health care provider that has tendered compensation benefits under subsection (a) not later than the date the provider makes the tender under subsection (a).

(5) Any action which would benefit from foreclosure of action against the entity under subsection (a) with respect to that injury, and (B) any action which would benefit from foreclosure of action against any entity which intentionally caused or intended to cause injury, except that this paragraph shall not apply to any personal injury unless the injured individual provides the provider making a tender with a notice of election not later than 90 days after the date that the tender of compensation benefits was made.

(6)(A) In this subpart:

(i) The term 'net economic loss' means—

(1) the amount of the liability of the provider for personal injury, the individual or another entity shall be joined in any tender

(ii) any action in the nature of a wrongful death action, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, or (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that (i) may be a basis for an award of damages for personal injury.

(ii) Any entity which has tendered (or deemed to have tendered) compensation benefits, with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.

(7) A health care provider which has tendered compensation benefits under subsection (a) may, by written notice to the entity, join in the foreclosure provided under subsection (a) any entity which is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the entity under subsection (a). A joint tender under this paragraph may only be by written notice to the entity to be joined and such notice shall not be effective if provided later than the date the provider makes the tender under subsection (a).

(8) Any entity which would benefit from foreclosure of action against the entity under subsection (a) with respect to that injury, and (B) any entity which would benefit from foreclosure of action against any entity which intentionally caused or intended to cause injury, except that this paragraph shall not apply to any personal injury unless the injured individual provides the provider making a tender with a notice of election not later than 90 days after the date that the tender of compensation benefits was made.

(9)(A) In this subpart:

(i) the term 'net economic loss' means—

(ii) any action in the nature of a wrongful death action, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, or (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that (i) may be a basis for an award of damages for personal injury.

(iii) any action in the nature of a wrongful death action, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, or (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that (i) may be a basis for an award of damages for personal injury.

(ii) Any entity which has tendered (or deemed to have tendered) compensation benefits, with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.

(10) A health care provider which has tendered compensation benefits under subsection (a) may, by written notice to the entity, join in the foreclosure provided under subsection (a) any entity which is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the entity under subsection (a). A joint tender under this paragraph may only be by written notice to the entity to be joined and such notice shall not be effective if provided later than the date the provider makes the tender under subsection (a).

(11) Any entity which has tendered (or deemed to have tendered) compensation benefits, with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.

(12) A health care provider which has tendered compensation benefits under subsection (a) may, by written notice to the entity, join in the foreclosure provided under subsection (a) any entity which is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the entity under subsection (a).

(13) Any entity which has tendered (or deemed to have tendered) compensation benefits, with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.
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whether, caused by pain and suffering or physical impairment, but not including non-economic damages as defined in paragraph (3), less collateral benefits (as defined in paragraph (1)).

(2) The term "allowable expenses" means reasonable expenses incurred for products, services, and accommodations reasonably necessary for medical care, training, and other remedial treatment and care of an injured individual, but includes expenses for rehabilitation treatment and occupational training only in accordance with subsection (d).

(3) The term "work loss" means 100 percent of the loss of income from work the injured individual would have performed if the individual had not been injured, reduced by any income from substitute work actually performed by the individual or by income the individual would have earned in available appropriate substitute work the individual was capable of performing but unreasonably failed to undertake.

(4) The term "replacement services loss" means reasonable expenses incurred in obtaining ordinary and necessary services in lieu of any actual or expected services the injured individual would have performed, not for income but for the benefit of the individual or the individual's family, if the individual had not been injured.

(5) The term "non-economic detriment means pain, suffering, injury, or impairment of mental anguish, emotional distress, punitive or exemplary damages, and all other general (as opposed to special) damages, including loss of earning capacity and loss of any of the following which would have been provided by an injured individual to another; consortium, society, companionship, comfort, protection, marital care, attention, advice, counsel, training, guidance, and education. Such term does not include pecuniary loss caused by pain and suffering or by physical impairment.

(6) The term "collateral benefits" means all benefits and advantages received or enti- tled to be received (regardless of time) by any other entity has or is entitled to assert for recoupment through subrogation, trust or assignment or otherwise by any injured individual or other entity as reimbursement of loss because of personal injury, payable or allowable expenses under paragraph (2) (A) the laws of any State or the Federal Government (other than through a claim for breach of an obligation or duty) or (B) any health or accident insurance, workmen's compensation plan or disability income insurance, except that no benefits payable with respect to an injury under a State plan approved under title XIX shall be considered to be collateral benefits for purposes of this sub- paragraph.

(c)(1) Compensation benefits shall include reasonable expenses incurred by the injured individual in collecting such benefits, including a reasonable attorney's fee. Such expenses may be offset from the amount of compensation benefits otherwise provided, if any significant part of a claim for compensation benefits is fraudulent or so excessive as to have no reasonable foundation.

(2) A compensation obligor defending a claim for compensation benefits shall be allowed an attorney's fee as an addition to other reasonable expenses incurred, in defending such a claim or part, thereof that are not recoverable as having no reasonable foundation. The fee or expenses may be treated as an offset to any compensa- tion benefits any other compensation obligor may recover from the claimant any part of the fee or expenses not offset or otherwise paid. (d) All reasonable expenses under subsection (b)(2)(A) include expenses for a procedure or treatment for rehabilitation and reha- bilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case, the expenses are reasonable in relation to the probable rehabilitative effects and the compen- sation benefits payable and is likely to contribute substantially to rehabi- litation, even though it will not enhance the injured individual's exercise capacity.

(3) All reasonable expenses shall not include expenses described in paragraph (1) with respect to a procedure or treatment for rehabilitation or a course of rehabilitative occupa- tional training which exceed $5,000 in any 30-day period unless the injured individual has provided the initiating compensation obligor with a grade, progress report, leav- ement, or course of training before expenses totaling $5,000 with respect to such procedure, treatment, or course of training during such period have been incurred.

PAYMENT OF COMPENSATION BENEFITS

"Sec. 1822. (a)(1) Compensation bene- fits shall be payable not less than 30 days after the date there is submitted to the beneficiary or compensation obligor, but the information, the date of occurrence of the fact and the date of the net eco- nomic loss occurred, except that payment may otherwise be paid in accordance with periods not exceeding 31 days, within 15 days after the end of the period. If reasonable proof is submitted of a portion of the net economic loss, and the portion totals $100 or more, the compensation benefits with respect to that portion shall be paid without regard to the remainder of the net economic loss. An injured individual to whom a tender of compensation benefits has been made under section 1821 shall be entitled to inter- est, at the annual rate of interest applied to judgments in the State in which the injury occurred, on such benefits not paid on a timely basis.

(b) If there elapses a period of five years after a claim for payment of net economic loss incurred by the injured individual or to the entity obligated to make payment, the claim shall be barred against the injured individual, unless the injured individual made or had knowledge of the making of the misrepresent- ation.

(c) If such entity secures judgment in an action under paragraph (1) the entity may offset amounts it is entitled to recover under such judgment against any compensa- tion benefits otherwise due.

REQUIRING DISCLOSURE OF FACTS ABOUT, AND MENTAL AND PHYSICAL EXAMINATION OF, INJURED INDIVIDUAL

"Sec. 1824. (a)(1) Upon request of an In- jured individual or compensation obligor, information relevant to payment of compensa- tion benefits shall be disclosed as follows:

(1) The injured individual shall furnish evidence of his individual earnings, if self-employed.

(2) An employer of the individual shall furnish evidence of his earnings of an injured individual who is or was an employee of the employer, for the period specified by the compensation obligor making the request, which may include reasonable periods before, and the entire period after, the injury.

(3) The injured individual shall deliver to the compensation obligor upon request a copy of every written report, not otherwise available to the compensation obligor, or examination of the injured individ- ual and the names and addresses of hospitals, physicians, and other entities examined; treating or providing ac- commodations to the individual in regard to the injury or to a relevant past injury, and the name and address of any person authorizing the compensation obligor to inspect and copy all relevant records made by such entities.

(3)(A) A hospital, physician, or other entity examining, diagnosing, testing, or providing accommodations to an injured individual in connection with a condition alleged to be connected with an injury upon which a claim is based, who is not the claimant or upon authorization of the injured individ- ual, shall furnish a written report of the history, symptoms, diagnosis, treatment, and date of treatment.
of the injured individual in connection with the injury or any previous or other condition which may be relevant to assessing such condition, and permit inspection and copying of such examination reports. Upon notice to all entities having an interest, the court may enter an order refusing discovery or specifying conditions of discovery and directing payment of costs and attorney fees for the proceedings, including reasonable attorney's fees.

(b)(1) If the mental or physical condition of any party is relevant to compensation benefits, a compensation obligor may petition a court having jurisdiction over the matter for an order directing the obligor to submit to a mental or physical examination by a physician. Upon notice to all interested parties and all entities having an interest, the court may make the order for good cause shown. The order shall specify the time, place, manner, conditions, scope of the examination, and the physician by whom it is to be made.

(b)(2) If requested by the individual examined, a compensation obligor causing a mental or physical examination to be made shall deliver to the individual examined a copy of the filing of the examination report or oral deposition. Upon notice to all entities having an interest, the court may enter an order refusing discovery or specifying conditions of discovery and directing payment of costs and attorney fees for the proceedings, including reasonable attorney's fees.

(b)(3) If any individual refuses to comply with an order entered under this subsection, the court may impose sanctions, but may not find an individual in contempt for failure to submit to a mental or physical examination.

(c) If a health care provider tends to an individual respecting the determination of whether or not an individual has a compensable condition, to be performed in the future if it is material and relevant to compensation benefits, a judgment may be entered for compensation benefits, other than with respect to that procedure, treatment, or course of rehabilitation the expenses of which are allowable expenses and the amount of which are an allowable expense and the amount of which are an allowable expense and the compensation obligor does not promptly undertake to be made. Any entity (other than the injured individual or a compensation obligor) providing information under this paragraph may charge the compensation obligor for declaratory relief under any other alternative liability program.

(d) A judgment for compensation benefits may be set aside for fraud.

(e)(1) Entities (including insurance companies) in a State may organize and maintain, subject to approval and regulation by the Secretary, an alternative liability program under this subpart, a health care provider must participate in an alternative liability program, and a health care provider who has not participated in an alternative liability program is not eligible to provide medical care, rehabilitation, rehabilitative occupational training, or clinical training in accordance with the requirements of this subsection.

(f)(1) An assignment of claims plan for the State providing for compensation benefits may be set aside for fraud.

(g)(1) Each assigned claims plan shall provide for the payment of compensation benefits by compensation obligors.

(h)(1) Entities (including insurance companies) in a State may organize and maintain, subject to approval and regulation by the Secretary, an alternative liability program under this subpart, a health care provider must participate in an alternative liability program, and a health care provider who has not participated in an alternative liability program is not eligible to provide medical care, rehabilitation, rehabilitative occupational training, or clinical training in accordance with the requirements of this subsection.

(i)(1) An assignment of claims plan for the State providing for compensation benefits may be set aside for fraud.

(j)(1) An assignment of claims plan for the State providing for compensation benefits may be set aside for fraud.
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It owes, the assigned claim plan shall promptly assign the claims to a member or
member of the plan and notify the individ-
ual or individuals entitled to receive such
benefits of the identity and address of the
assignee, or member or members of the plan,
as assigned so as to avoid inconvenience to
injured individuals. Any such assignee shall
have all rights and obligations as if it had
lawfully obligated itself to pay such compen-
sation benefits and the plan and assignee
may seek payment (including interest) from
the compensation obligor or its succes-
sor of 120 percent of the costs and expenses
incurred in fulfilling the obligor's obliga-
tions.

If the plan is due to an individual
against whom an assigned action
is brought, the plan may seek
payment from the individual
and its successor for
the costs and expenses
incurred in fulfilling
the plan's obliga-
tions.

A. The restrictions of subparagraphs
(A)(1)(A) and (B) shall not apply to the
disclosure, upon the request of a health care
professional against whom an adverse action
is taken by the institutional health care
provider of information relating to that profes-
sional, but only if the disclosure is made in a
proceeding to determine the hawfulness of
the adverse action.

In the case of a health care professional
who is a member of (or who has applied for
membership in) the medical staff of the provider
and (i) the minutes, analyses, findings,
deliberations, and reports of a peer review com-
mitee;

(B) Except as provided in subparagraph
(C), no one shall disclose—

(1) the identity of an entity that provides
information to an institutional health care
provider or to a peer review committee
concerning the professional incapability or
incapacitability of a health care professional
who is or was a member of (or who has
applied for membership in) the medical staff of
the provider;

(2) any committee of the medical staff
of an institutional health care provider
assisting the governing body in a peer review
activity within the authority of the functions
delineated by the governing body;

(3) the term "professional incapability"
means professional incompetence, mental or
physical impairment, or unprofessional or
unethical conduct.

"REQUESTING MALPRACTICE INSURANCE
FOR PHYSICIANS TO OBTAIN BENEFITS OF
SUBPART A—Sec. 1824. A health care
professional described in subsection 1824(b)(1)
may not participate in the alternative liability pro-
gram under this subparagraph unless the profes-
sional has insurance against professional
malpractice or has suitable bond or other indem-

(1) the term "professional incapability"
means professional incompetence, mental or
physical impairment, or unprofessional or
unethical conduct.

"REQUESTING MALPRACTICE INSURANCE
FOR PHYSICIANS TO OBTAIN BENEFITS OF
SUBPART A—Sec. 1824. A health care
professional described in subsection 1824(b)(1)
may not participate in the alternative liability pro-
gram under this subparagraph unless the profes-
sional has insurance against professional
malpractice or has suitable bond or other indem-
nity against liability for professional mal-
practice at least in such amount as the Sec-
retary determines is appropriate, based on the
amounts that are consistent with the insurance
or bond maintained by professional
in the case involved.

"EFFECTIVE DATE AND APPLICATION OF
ALTERNATIVE STATE MEDICAL LIABILITY LAW
—Sec. 1826. Notwithstanding any other
provision of this Act, the preceding provi-
sions of this subpart shall not apply to any person
who is a member of (or who has applied for
membership in) the medical staff of an institutional health care
provider or to any entity transmitting to an
institutional health care provider information bearing on the professional incapability of the professional.

unlawful...

27.4:11'
the settlement other third parties (potential defendants) who may be responsible for the injury. Similarly, other third parties may request to be joined. Any disagreement between the joined parties will be settled by binding arbitration.

Patient Protections. - 1. The patient's rights to sue for the enforcement of the commitment are protected should the... from suit for those who review health care professionals' conduct and those who take disciplinary action against them.

Mr. DANFORTH. Mr. President, I am pleased to join my colleague on the Senate Finance Committee, Senator DILLINGER, as... addresses one of the Nation's critical health care problems—the spiraling cost of medical malpractice insurance.

In my own State of Missouri, malpractice insurance rates for family practice physicians rose by 135 percent this year, and hospital insurance costs increased by more than 150 percent. The problem is particularly severe in obstetrics and gynecology, where skyrocketing malpractice insurance rates are discouraging many rural physicians from performing such services and greatly diminishing the availability of care to high-risk maternal patients, who in many cases are poor.

In the Wavel Clinge Clinic in Clinton, MO, which provides care to a wide rural area in the western part of the State, 7 of 10 doctors who used to deliver babies have been squeezed out of this essential part of their practice by insurance rate increases.

Paced with a tenfold increase in its medical malpractice insurance premiums, Truman Medical Center, a public hospital in Kansas City, was forced to seek a $1.5 million loan from the city to form a self-insurance pool and avoid closing down or operating without insurance. A recent series of medical malpractice jury awards in excess of $10 million has made commercial reinsurance coverage virtually unavailable in western Missouri.

As these examples clearly demonstrate, the medical malpractice insurance crisis is not a problem faced only by doctors and hospitals—it is a problem which affects every one of us. The costs of medical malpractice—which include not only the rising price of insurance, but also the cost of additional tests and procedures ordered by doctors primarily to guard themselves against lawsuits—are paid by employers and individuals in the form of higher health insurance premiums and higher taxes.

This malpractice insurance crisis is but one facet of a much larger problem affecting all purchasers of liability insurance. Accountants, truck drivers, commercial fishermen, municipal governments, and many other groups also are confronting huge increases in the cost of insurance coverage. Indeed, the problem of cost and availability of liability insurance is so widespread and severe that it is becoming one of the most pressing economic issues the country faces today.

At the heart of the problem is a complicated and expensive civil justice system which consumes more money determining fault than compensating victims. If we are to get at the true cause of our insurance woes—in medical malpractice and other areas—something must be done to provide for more just and predictable awards to injured parties, while reducing the massive expenditures associated with litigating disputes.

Although I am not yet certain that the legislation introduced today provides the best proposal for civil justice reform in the medical malpractice area, it is an important beginning. The Medical Offer and Recovery Act would provide for an alternative compensation scheme similar in design to legislation I have sponsored with regard to products liability. The goal is to get people out of the court system and to encourage swift and certain compensation for products liability. The products bill is moving ahead in the Commerce Committee, and I look forward to working with the legislation in the Finance Committee.

While I support the concept of setting up alternative to formal court litigation of personal injury disputes, I am also aware that tort law reform is an issue within the purview of the States. Many States, including Missouri, have been very active recently in attempting to reform their laws governing personal injury litigation. This legislation is not attempting to discourage these efforts, but rather to complement and support them.

Mr. President, the Medical Offer and Recovery Act is directed at a complex problem, and there are a number of competing interests involved. While the task ahead is a challenging one, I am encouraged by the prospect of real reform that would benefit both the providers and consumers of medical care.

By Mr. THURMOND (for himself, Mr. DECONCINI, Mr. ANDREWS, Mr. BURDICK, Mr. D'AMATO, Mr. DIXON, Mr. STROM, and MR. WARNER) (by request):

S. 961. A bill to amend title 28 and title 11 of the United States Code to authorize a new U.S. trustee system by providing for the appointment of U.S. trustees to supervise the administration of bankruptcy cases in judicial districts throughout the States, and for other purposes; to the Committee on the Judiciary.

UNITED STATES TRUSTEES ACT

Mr. THURMOND. Mr. President, on behalf of the administration, I rise to introduce the United States Trustee Act of 1985. This bill would expand and make permanent the U.S. Trustee Pilot Program for Bankruptcy Administration, which was established by title I of the Bankruptcy Act of 1978 (Public Law 95-959). The initial period for the project was 4½ years, but it was extended twice: First until September 30, 1984 (Public Law 98-166); and again until September 30, 1986 (Public Law 98-353).

The U.S. trustees would be charged with overseeing the administration of bankruptcy cases filed under chapters 7, 11, and 13 of the Bankruptcy Code. Under the act of the Justice Department, the U.S. trustee position would be filled by a U.S. trustee appointed by the Attorney General for a 4-year term.

This legislation would expand the pilot program from 10 field offices covering 18 judicial districts to 30 regional offices covering the entire United States. The nonpilot areas, the bankruptcy judges have continued to adjudicate legal issues and to supervise the administration of bankruptcy cases.

This legislation would expand the pilot program from 10 field offices covering 18 judicial districts to 30 regional offices covering the entire United States.
The 1986 AAMC Annual Meeting will be held October 25-30 in New Orleans. The Council of Academic Societies is scheduled to meet on Sunday, October 26 and Monday, October 27. As in previous years, the Sunday session will be consist of a plenary session devoted to an issue of interest to faculty. The program for this meeting must be decided at this Board meeting so that it may be included in the preliminary program for the Annual Meeting. Possible speakers for the program may be identified at this time.

The Monday afternoon session will include the Council business meeting and a discussion of current issues and directions for the CAS. The program for Monday's meeting will be discussed at a future Board meeting.
The Executive Council has authorized the establishment of an ad hoc committee on graduate medical education and the transition from medical school to residency. The AAMC has been concerned about the graduate phase of physicians' education for many years, and in 1981 issued a task force report entitled, "Graduate Medical Education: Proposals for the Eighties." Now, midway through the decade, there are mounting concerns about the disruption of medical students' education by the intensity of competition for residency positions.

In reviewing the positions the Association has taken about graduate medical education during the past 20 years, it appears that a genuine continuum between medical school and graduate medical education has never been attained. Indeed, the continuum concept now appears more tenuous than it did a decade ago. For this reason, the committee has been asked to consider what should be done to alleviate what has been called the "prereresidency syndrome," to review the history of the Association's policies about institutional responsibility for graduate medical education, and to recommend to the Executive Council what the AAMC and its constituent institutions and organizations should do to achieve a true continuum of medical education.

AAMC AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

SPENCER FOREMAN, M.D., CHAIRMAN, President, Sinai Hospital, Baltimore
AAMC GME Task Force 1977-1981; AAMC representative to ACGME

D. KAY CLAWSON, M.D., Executive Dean, University of Kansas Medical Center
School of Medicine
AAMC GME Task Force 1977-1981; AAMC representative to ACGME; former
Chairman, RRC, Orthopedics

ARNOLD L. BROWN, M.D., Dean, University of Wisconsin Medical School

JOSEPH S. GONNELLA, M.D., Dean, Jefferson Medical College, Philadelphia

ROBERT DICKLER, Director, University Hospital, Denver, Colorado

JAMES J. LEONARD, M.D., Chairman, Department of Medicine, Uniformed Services
University of the Health Sciences
President, Association of Program Directors in Internal Medicine
MORTON E. SMITH, M.D., Professor of Ophthalmology, and Assistant Dean,  
Washington University School of Medicine

MARK L. DYKEN, M.D., Chairman, Department of Neurology, Indiana University  
School of Medicine

J. ROLAND FOLSE, M.D., Chairman, Department of Surgery, Southern Illinois  
University School of Medicine  
Chairman, RRC, Surgery

THOMAS K. OLIVER, JR., M.D., Chairman, Department of Pediatrics, University  
of Pittsburgh School of Medicine  
Chairman, American Board of Pediatrics

VIVIAN W. PINN, M.D., Chairman, Department of Pathology, Howard University  
College of Medicine  
Former Dean for Student Affairs, Boston University School of Medicine

BERNICE SIGMAN, M.D., Associate Dean for Student Affairs, University of  
Maryland School of Medicine

GERALD H. ESCOVITZ, M.D., Vice-Dean, Medical College of Pennsylvania  
Chairman-Elect, Group on Medical Education

CAROL M. MANGIONE, M.D., Resident, Internal Medicine, University of California,  
San Francisco School of Medicine  
Former member, OSR Administrative Board; Member of Advisory Committee  
for the Conference on the Clinical Education of Medical Students

Ex-officio Members:

VIRGINIA V. WELDON, M.D., Professor of Pediatrics, and Associate Vice  
Chancellor for Medical Affairs, Washington University School of  
Medicine  
Chairman, AAMC Assembly

EDWARD J. STEMMLER, M.D., Dean, University of Pennsylvania School of  
Medicine  
Chairman-Elect, AAMC Assembly

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1986 CAS NOMINATING COMMITTEE

The following individuals have agreed to serve on the 1986 CAS Nominating Committee:

Frank G. Moody, chairman
Jo Anne Brasel
David H. Cohen
Rolla Hill
Mary Lou Pardue
Jerry Wiener
Nicholas Zervas

The Committee will meet via conference call in May.