ACADEMIC MEDICINE IN A COMPETITIVE HEALTH CARE ENVIRONMENT: STRATEGIES FOR MANAGEMENT
—Jeff Goldsmith
Director, Office of Health Planning & Health Regulatory Affairs
University of Chicago Medical Center

1:00 p.m.-UNSCHEDULED TIME

Wednesday, March 31st

SESSION VI

8:30 a.m.- *Club*
9:30 p.m. *Conference*

VA-MEDICAL SCHOOL AFFILIATIONS: A PARTNERSHIP UNDER STRESS
—Donald L. Custis, M.D.
Chief Medical Director
Veterans Administration

9:30 a.m.-COD BUSINESS *Club*
12 Noon MEETING *Conference*

12 Noon Adjournment

PROGRAM PLANNING COMMITTEE

—William H. Luginbuhl, M.D.
—Steven C. Beering, M.D.
—David R. Challoner, M.D.
—Richard Janeway, M.D.
—Julius R. Krevans, M.D.

Association of American Medical Colleges

COUNCIL OF DEANS SPRING MEETING

PROGRAM

ACADEMIC MEDICINE—EXPLORING THE TASKS AT HAND: EXPANDING RESOURCES-CONTRACTING PROGRAMS

March 28 - 31, 1982
Kiawah Island
Charleston, South Carolina

1982 SPRING MEETING OF THE COUNCIL OF DEANS

March 28 - 31, 1982
Kiawah Island

ACADEMIC MEDICINE—EXPLORING THE TASKS AT HAND: EXPANDING RESOURCES-CONTRACTING PROGRAMS

PROGRAM

Sunday, March 27th

1:00 p.m.- 5:00 p.m. ARRIVAL & REGISTRATION — *Brigantine Foyer*

SESSION I

5:30 p.m.- 7:00 p.m. WELCOME & PRELUDE TO COD BUSINESS MEETING — *Club Conference*

7:00 p.m.- 8:30 p.m. RECEPTION — *Brigantine #1*

Monday, March 29th

SESSION II

8:30 p.m.- 10:30 a.m. — *Club Conference*

A LOOK AT THE ECONOMIC AND POLITICAL CLIMATE FOR MEDICINE
—Robert Blendon, ScD
Vice President
The Robert Wood Johnson Ftd.

MEDICAL EDUCATION IN THE US: A STATUS REPORT
—John A.D. Cooper, M.D.
President
AAMC

10:30 a.m.-BREAK
11:00 a.m. — *Club Conference*

SESSION III

11:00 a.m.- 1:00 p.m. — *Club Conference*

MEDICINE AND SCIENCE: A PERSPECTIVE ON THE FEDERAL ROLE
—Senator Harrison Schmitt
New Mexico

ACADEMIC MEDICINE AND THE PROFESSION: REFLECTIONS ON THE RELATIONSHIPS
—Lowell H. Steen, M.D.
Immediate-Past-Chairman of the Board of Trustees
American Medical Association

1:00 p.m.-UNSCHEDULED TIME

Tuesday, March 30

SESSION IV

8:30 a.m.- 10:30 a.m. — *Club Conference*

EFFECTING MORE EFFICIENT MANAGEMENT: THE UNIVERSITY OF VERMONT EXPERIENCE
—Lattie F. Coor, Ph.D.
President
University of Vermont

ENGAGING THE PROCESS OF CONSOLIDATION: THE ALBANY MEDICAL COLLEGE EXPERIENCE
—Robert L. Friedlander, M.D.
President
Albany College

MANAGING FINANCIAL EXIGENCY: THE MICHIGAN STATE EXPERIENCE
—W. Donald Weston, M.D.
Dean
Michigan State University

10:30 a.m.-BREAK
11:00 a.m. — *Club Conference*

SESSION V

11:00 a.m.- 1:00 p.m. — *Club Conference*

AN EXPERIMENTAL BUDGETING SYSTEM
—John Gronvall, M.D.
Dean, School of Medicine
University of Michigan

DEVELOPING PHILANTHROPY FOR INSTITUTIONAL SUPPORT
—J. Michael Mattson
Executive Director
Development Office
University of Utah

aamc association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

SPRING BUSINESS MEETING

SESSION I
SUNDAY, MARCH 28, 1982
5:30 P.M.-7:00 P.M.

SESSION II
WEDNESDAY, MARCH 31, 1982
8:30 A.M.-12 NOON

CLUB CONFERENCE CENTER
KIAWAH ISLAND INN
CHARLESTON, SOUTH CAROLINA

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

COUNCIL OF DEANS
SPRING BUSINESS MEETING
Club Conference
Kiawah Island Inn
Charleston, South Carolina

AGENDA

Agenda Continued

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS

ANNUAL BUSINESS MEETING
Monday, November 2, 1981
2:00 pm - 5:00 pm
Georgetown East & West
Washington Hilton Hotel
Washington, D.C.

MINUTES

I. Call to Order

The meeting was called to order at 2:00 pm by Steven Beering, M.D.

II. Program Session

Dr. Beering began the program by welcoming and introducing the senior representatives of the Veterans Administration office of the Chief Medical Director for a presentation to the COD entitled, "Medical District Initiated Program Planning--The Veterans Administration's Strategic Planning Effort."

Dr. Donald Custis, Chief Medical Director of the VA, introduced the Medical District Initiated Program Planning. Dr. Custis explained that this strategic planning effort is aimed at curtailing the centralization of authority within the VA. He considered that substantial local district and regional participation in planning is a key to increasing the VA's cost effectiveness at a time when resources are diminishing and the demand for services are increasing. He maintained that the need for an integrated strategic plan is further accentuated by the current emphasis on the competitive medical model and the pending legislation that increases entitlements while simultaneously reducing the funding for such programs as medicare and medicaid.

Dr. Murray Mitts, Director of Program Analysis and Development at the VA, elaborated on the MEDIP program. Dr. Mitts noted that one of the VA's functions is to provide the full array of medical programs in each of the 28 districts. To accomplish this, he emphasized that the planning process should be integrated to include recommendations from the bottom (districts) as well as strategic guidance from the top (Chief Medical Director - CMD). Dr. Mitts explained that there are four categories of activity in this process with the District Planning Committee being of crucial importance. It is at this point in the process where the deans committee and the universities can have their greatest influence and impact. He described the analytical methodology used. A first step involved the development of an appropriate data base including: a current capability inventory, a current demand analysis and a current demography.

In concluding the program session, Mr. Malcolm Randall, Director of the VA Medical Center in Gainesville, Florida, presented the perspective of the districts with regard to the MEDIP program. His first concern was that the program was attempting to achieve too much too fast, but conceded that there was no alternative. Secondly, he expressed concern that the districts could no longer wait to set their strategic directions as there are several other persons willing to take that initiative away. Mr. Randall emphasized the importance of including clincians in the planning process. This was premissed on the fact that these are clinical programs under consideration and that clinicians' participation is essential to sound decision making.

III. Quorum Call

Dr. Beering announced the presence of a quorum.

IV. Chairman's Report

Dr. Beering began by reflecting the past year's areas of concerns discussed at the various meetings of the Administrative Board and Executive Council. He explained that the unifying theme over the past year was an analysis of "the competitive medical model" and its potential impact on academic medicine--our system for research, education, technology transfer, and care of the poor and the elderly. He urged all citizens of our universities and communities to affirm the notion that at the very basis of all progress is education.

Dr. Beering then elaborated on this year's Annual Meeting theme "Tommorrow's Medicine--Art and Science, Commerce and Industry". In fact, these discussions constituted a continuation of discussions that were held at the Spring Meeting of the Council of Deans in Colorado. He expressed his hope that this meeting would stimulate thoughtful consideration of what tomorrow may bring and what must be done to shape the future.

Dr. Beering then presented the highlights of the September Retreat held in conjunction with the Executive Council meeting which included the Administrative Boards and Executive Council members. This symposium entitled, "Strategies for the Future" was designed to involve a large and diverse group of individuals in a cross-cutting participative series of discussions to learn how the AAMC might cope with a future which appeared very different from the past. Among the conclusions of those deliberations were: urge that the AAMC should play a more significant role in communications to the medical schools' internal and external constituencies; that a key role for the Association was that of a broker--the medium through which to share experiences and expertise on common problems.

In concluding, Dr. Beering stated that these meetings over the past year were not just single events on a curve but part of a process which is ongoing. He urged the deans to provide their personal views as input to the next step of the process, the Officer's Retreat in December.

V. President's Report

Dr. Cooper began his report by thanking Dr. Beering and the Administrative Board for the tremendous job they had done over the past year in sorting through the myriad of problems and issues which faced the Association. The Board's efforts above and beyond the call of duty have provided an effective response in helping develop the Association's positions and directions.

While a report on the state of the Congress and the Administration is usually presented, Dr. Cooper explained that this report would take place at the Assembly meeting on Tuesday so that members of all the Councils would hear the report at the same time.

Dr. Cooper devoted this presentation to a consideration of some of the problems to be faced by society and the role medicine particularly academic medicine, would need to play. Within that context he sketched some of the current and projected activities of the AAMC. One of the most important priorities for our profession today is to devise new and more efficient methods of caring for the elderly. He reminded us that while other factors having played their part, the role of medicine had certainly been a key in the changing demographics of our population. Over the past year the AAMC has been working closely with the Administration on Aging in helping coordinate programs of the long term gerontology centers.

Dr. Cooper announced that the Association just received funding by The Glen Meade Trust to undertake a series of regional conferences on geriatrics and gerontology in medical education. This effort will be chaired by Joseph Johnson, Chairman of Medicine, Bowman Gray College of Medicine, and Chairman of the Association of Professors of Medicine. This program would be underway soon; the appointments of a Steering Committee is currently in process. The hope is to have the program finished and a report back to the deans and councils at the next Annual Meeting.

Dr. Cooper further commented on the supply and distribution of physicians. The Rand Study has indicated that with the increasing number of physicians entering practice, there has been a tremendous improvement in the geographic distribution of physicians and specialists into the more rural areas and that the number of individuals in the U.S. who are not close to available medical care is diminishing very rapidly. As a result, there is no question that further increases in the number of physicians will have a further effect on distribution. However, the question remains whether we are overdoing it and whether the competition between physicians will become excessive and detrimental to the quality of care which we provide.

Dr. Cooper reported that the AAMC efforts in the field of Continuing Medical Education (CME) have had an important impact. Many of the recommendations have been incorporated into the essentials for the accreditation of CME programs. The Accreditation Council for Continuing Medical Education has begun to expand the requirements for accreditation

beyond just the offering of a course, but to include consideration of the important questions--whether the program is of educational benefit which really meets the needs of the physician.

Dr. Cooper noted that the AAMC report on GME has also had an impact. Its recommendations have been incorporated into the new essentials for GME and there has been generated an increased awareness of the responsibility of the faculty of the institution as a whole for maintaining resource availability and the quality control for GME programs.

The Kaiser Family Foundation has agreed to provide grant support for the General Professional Education of the Physician (GPEP) study. It has been designed as a three-year study and will involve a steering committee chaired by Dr. Steven Muller, President of Johns Hopkins, and co-chaired by Dr. William Gerberding, President of the University of Washington. Our study will be coordinated with the Carnegie Foundation supported effort undertaken by the Association of Higher Education which is exploring the meaning of the BS degree and its role in professional education. Dr. Cooper indicated that this is the first major review of medical education since the consensus had developed that the pre-MD education is just one segment in what is now a longer continuum. Ninety-six percent of the students graduating from medical school now enter into residency training.

Dr. Cooper assured the deans that Marjorie Wilson's important contributions of focusing the Association's attention on the need and desire of deans for assistance in enhancing their management capabilities is much appreciated and highly regarded. Her departure to take up new challenges in no way should be interpreted as a decline of interest in this area. While there will be some rebuilding to do, we will be pursuing new initiatives and directions for this program in adapting to the ever changing environments of the future.

In concluding, Dr. Cooper reocgnized Dr. James Schofield, Director of the AAMC Division of Accreditation, on the occasion of his ten year anniversary with the AAMC. Dr. Cooper congratulated Jim on the excellent work as Director of the Division and as Alternate Secretary of the LCME.

VI. Consideration of Minutes

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

VII. Consideration of Assembly

A. Election of Institutional Members

The COD on motion, seconded, and carried, recommended the election of the East Carolina School of Medicine, the Marshall University School of Medicine, the Texas A & M University College of Medicine, the Ponce Medical School, the University of South Carolina School of Medicine, and the Northeastern Ohio Universities College of Medicine to Full Institutional Membership by the AAMC Assembly.

B. Election of Distinguished Service Membership

The COD on motion, seconded, and carried, recommended that the AAMC Assembly elect the following individual to Distinguished Service Membership:

Robert L. Van Citters, M.D.

C. Proposed By-law Changes

Mr. Keyes described the proposed by-law changes of Article VI, Sections 2 and 7. Section 2 would institutionalize the practices of the CAS and COTH to elect their Immediate-Past-Chairman and their Chairman-Elect to the Executive Council and would extend that practice to the COD. In addition, it was recommended to have the Immediate-Past-Chairman of the Assembly to continue on the Executive Council for one additional year in that capacity. The proposed Section 7 of this article was intended to clarify when there is a vacancy on the Council and to specify that the Executive Council can, at its own discretion, appoint a person to fill the unexpired term or leave it to an election at the Assembly. Finally, the provision specifies that any person elected to an unexpired term continues to be eligible for two complete terms.

The COD on motion, seconded and carried, endorsed the amendment of Article VI, Sections 2 and 7 of the Association By-laws as recommended by the Executive Council.

Mr. Keyes further explained the proposed by-law changes of Article I Sections 2B and 3E. Proposed by-law changes under Section 2B proposed the deletion of the requirement that Distinguished Service Memberships "no longer serve as an AAMC representative of any member." Instead it specifies that individuals elected to DSM shall have made major contributions to the Association and its programs. Secondly, the proposal would specify the Executive Committee of the Association as a nominating committee to present the names to the Executive Council. It was recommended that the COD endorse the Association by-laws as proposed by the Executive Council.

Dr. Bruce Lewis rose to discuss this proposed by-law change. He expressed the view that there is a need to develop some mechanism for maintaining in the Association those people who have much information experience in the AAMC activities, but who no longer were active members of one of the three councils.

The Council of Deans on motion, seconded and carried, endorsed the proposed amendment of the Association By-laws as recommended by the Executive Council.

VIII. COD Rules and Regulations Changes

The COD on motion, seconded and carried, approved the Rules and Regulations amendments as proposed by the Administrative Board and approved by the Executive Council.

These changes in the Rules and Regulations include removal of the specification of a meeting with the AMA Congress on Medical Education and removal of the requirement that groups meet on a regional basis at least once a year. In place of this requirement is a codification of the decisions regarding "sections" made over the past few years.

IX. Report of the Nominating Committee and Election of Officers

On recommendation of its nominating committee and on motion, seconded, the COD elected Chairman-Elect of the COD, Richard Janeway, M.D., The Bowman Gray School of Medicine of Wake Forest University; for Member-at-Large, William B. Deal, M.D., University of Florida, D. Kay Clawson, M.D., University of Kentucky, Arnold L. Brown, M.D., University of Wisconsin.

X. Information Item

A. AAMC General Professional Education of the Physician Project

Dr. Beering referred the deans to additional background information and recalled that Dr. Cooper spoke on GPEP earlier in his report to the Council.

XI. Old Business

Dr. Janeway introduced a resolution of appreciation for the work of Dr. Marjorie P. Wilson, former Director of the Department of Institutional Development now presently Senior Associate Dean of the School of Medicine at the University of Maryland.

> WHEREAS, for the past 11 years, Marjorie Wilson has contributed substantially to the success of the Council of Deans, and
> WHEREAS, she has willingly given of her head and heart, her wisdom and thoughtfulness, and indeed a not infrequent shoulder, and
> WHEREAS, she was the architect of the Association's Management Advancement Program that has imparted the skills and insights to us that surely will help us in the coming years--and for 100 other things our friend and den mother has done for us and the AAMC,
> BE IT RESOLVED by acclimation that the Council of Deans express its gratitude and appreciation to Marjorie, our friend and colleague--and further, to wish her every success in her new career at the University of Maryland

Adopted by standing ovation.

XII. New Business

A. Appreciation

Dr. Beering thanked Dr. Al Mathies and Dr. David Challoner, whose terms on the Board had expired and for their service to the COD Administrative Board. He presented them with engraved silver bowls marking their services as tokens of appreciation.

Stating it had been his pleasure and privilege, Dr. Beering thanked the Council of Deans then turned the proceedings over to Dr. William Luginbuhl.

Dr. Luginbuhl, as his first order of business, recognized Dr. Beering and thanked him for his many contributions to the Council of Deans and presented him with a gaval on behalf of the council as a token of appreciation.

XIII. Adjournment

The meeting was adjourned at 5:00 pm.

Strategies for the Future
An AAMC Work Plan

Underlying the work plan was a consensus by the officers and staff of the Association that in responding to the changing environment, medical schools and teaching hospitals must:

--define their missions more clearly in terms of the expectations of the faculty, students and the parent university, taking into consideration the view of the external constituencies to which they relate

--strengthen strategic planning to permit maximal use of resources

--identify new sources of support compatible with their missions

--be prepared to modify the mission and allocation of resources to accommodate zero growth or retrenchment

--maintain the quality of their programs

I. STUDENTS

Goal: Maintain an applicant pool of sufficient size, quality, and diversity

- Monitor career plans of college students through data from ACE, AAMC and other sources to predict dimensions of applicant pool

- If pool appears to be falling below an acceptable level:

  --develop campaign to inform high school and college counsellors of opportunities in medicine

  --increase activities to implement work plan adopted by the Executive Council for recruiting minority students

  --assist public schools with data and support to relax restrictive admissions policies

- Make efforts to incorporate 23 schools not now using AMCAS

- Continue Medical Sciences Knowledge Profile program to assist schools with the evaluation of candidates for advanced standing admissions

Goal: Obtain financial assistance to permit admitted students to matriculate and continue their medical education

- Continue efforts to include adequate student financial aid measures in federal authorization and appropriations legislation
- Analyze innovative approaches at the state level and disseminate information including model state legislation for use by AAMC constituents
- Involve the AAMC's National Citizens Advisory Committee in exploring private sector opportunities for new approaches to student aid programs
- Collect and distribute information on work study and cooperative education programs underway or being considered at professional schools

Goal: Maintain a spectrum of medical students of sufficient size, quality, diversity and career goals to meet the medical needs of society

- Develop an environment which allows and encourages personal development and growth
- Develop career counseling and specialty choice services for students which reflect societal needs and accommodate students' goals
- Develop tracking plan so institutions can assess how their graduates are fulfilling society's needs

II. GRADUATE MEDICAL EDUCATION

Goal: Strengthen the quality of graduate medical education

- Analyze data showing drop in PGY-1 positions to determine effect on graduates' ability to enter training programs in specialties and institutions they prefer
- Work with ACGME and RRCs and their sponsors to assure high quality of programs in graduate medical education
- Work through ACGME to assure that subspecialty training experiences include a meaningful research component
- Assure competence of residents from non-LCME accredited schools by continuing efforts with ACGME and its parent organizations to implement the recommendations of AAMC's Clemente and Luginbuhl committees to include personal assessment of clinical schools of these individuals prior to their admission to training programs

III. FACULTY

Goal: Maintain a faculty of a high quality in sufficient numbers to meet the diverse missions of medical schools

- Assist institutions in the planning of tenure policies and the development of alternative career opportunities for older faculty
- Promote methods to recruit and maintain young faculty
- Exert efforts to continue federal support for biomedical research training with special emphasis on institutional training grants for both the basic and clinical sciences and the Medical Sciences Training Program for M.D.-Ph.D. candidates
- Disseminate the findings of the AAMC study on The Status of Medical School Faculty and Clinical Research Manpower 1968-1990
- Through the ACGME require major research emphasis in subspecialty training programs to provide adequately trained clinical faculty for the future
- Assist institutions in involving and retaining the services of talented and committed voluntary faculty

Goal: Faculties should be made aware of and involved in the national issues that threaten biomedical research progress and the stability of their institutions

- Continue to disseminate information on national issues to faculties through their disciplinary societies
- Arrange meetings between faculty and key Congressional and Administration staff
- Work with deans to improve communication of critical issues to faculties including broader distribution of AAMC Weekly Activities Report
- Explore the need to communicate directly to faculty through the mailing list of the Faculty Roster

Goal: Reaffirm commitment to excellence in teaching

- Encourage faculty recognition and advancement based on teaching achievement as well as other faculty responsibilities
- Encourage continuous exploration of innovative teaching methods

IV. FINANCIAL VIABILITY AND PUBLIC SUPPORT

Goal: Maintain the financial viability of hospitals sponsoring or participating in clinical education to assure that the quality of their educational efforts remains high

- o Continue efforts to describe the multiple contributions and distinctive costs of teaching hospitals
- o Work with third party payers (HCFA, state Medicaid directors, Blue Cross Plans, commercial insurers) to help ensure an understanding and willingness to underwrite the distinctive costs of teaching hospitals
- • Advocate the appropriateness of using health service funds to finance the costs of graduate medical education including trainee stipends and benefits, program operations, supervising faculty, and general hospital overhead
- • Assess the need for new Association initiatives to secure adequate capital funding for teaching hospitals

Goal: Maintain the teaching hospitals' primacy in the introduction and evaluation of new technologies and the provision of tertiary care services

- • Develop an Executive Council position on national and state health planning legislation
- • Develop and advocate proposals designed to ensure that hospitals providing tertiary care services are adequately compensated for these services in spite of the patient's inability to personally pay for the service
- • Study models of hospital organization and incorporation to assess the usefulness of related research institutes, educational institutes, and philanthropic foundations
- • Advocate full payment for professional medical services personally provided or personally supervised by faculty physicians

Goal: Assist medical schools in dealing effectively with new fiscal constraints

- • Develop Management Advancement Programs to deal with issues such as reduction in size of class or faculty, retrenchment or elimination of programs, and sharing of resources
- • Develop data and rosters of consultants available to institutions needing help with particular problems
- • Be prepared to assist institutions in reconciling divergent decisions reached by different components of a medical center as they re-examine their primary mission

- Develop information for sharing among institutions on innovative alternatives to tenure and methods to provide new faculty opportunities during a period of no-growth

- Make institutions aware of Association's tenure model and facilitate its usage

- Determine whether sharing of resources among programs of a university or between medical schools can assist schools in maintaining the quality of their educational programs

- Identify institutions where such sharing has occurred and distribute information to constituents

Goal: Increase public awareness of the activities and contributions of academic medical centers

- Encourage medical schools to invite local Congressional staff delegations to visit medical schools and learn of their activities

- Make medical school deans and faculty and teaching hospital administrators more aware of effective means of transmitting institution's message to the community

V. MAINTAIN THE ACADEMY

Goal: Promote the development of rigorous criteria for accreditation of medical education programs by the Liaison Committee on Medical Education

- Work with the AAMC representatives to the LCME to clarify and define quality criteria

Goal: Maintain biomedical research as a central mission of academic medical centers

- Continue efforts to support federal investment in biomedical research and research training through NIH, ADAMHA and VA

- Assist institutions in identifying and developing research support from both for-profit and not-for-profit entities in the private sector

- Explore ways to provide base support for research (e.g., capital equipment) from institutionally generated funds (e.g., practice plans)

Goal: Assure that medical schools' goals are not distorted by commercial enterprises

- Work with NIH in its effort to sponsor a conference on university-industry relations

- Develop and maintain information on medical school-industry agreements which can be shared with interested medical schools

Goal: Protect and enhance the integrity and credibility of biomedical research and research scientists

- Assist deans and department chairmen to improve procedures for preventing fraudulent research and to deal with perpetrators when fraudulent research is detected
- Work with the academic societies to increase the stringency of editorial review of scientific papers published in sponsored journals
- Enhance awareness of senior investigators of their responsibility to supervise and monitor the research done by junior colleagues

Goal: Maintain the quality of medical school programs as retrenchment becomes necessary

- Develop management advancement programs to assist deans and chairmen to reduce or eliminate programs and faculty that are not essential to the mission of the academy
- Provide a clearinghouse for consultants to assist troubled institutions

Goal: Stimulate continuing appraisal and any modification necessary to ensure that medical education programs effectively accomplish each institution's educational mission

- Use the resources available through the General Professional Education of the Physician project to focus schools' attention on their educational programs
- Continue efforts to develop standards for meaningful continuing medical education activities

Goal: Nurture and strengthen the relationships between the medical schools and their universities

- Continue the AAMC interactions with ACE, AAU, and NASULGC to assure that organizations of university presidents are aware of newly developing medical education and biomedical research issues
- Maintain a close integration of the clinical phases, both undergraduate and graduate medical education, with the university structure

VI. PRO BONO ACTIVITIES

Goal: Maintain the pre-eminent role of the U.S. in advancing knowledge through biomedical research

- Develop methods of communicating the importance of research to the general public by linking it with technological advances, improvements in the welfare of the public and the nation's economic position with the world

- Protect and preserve the National Institutes of Health by opposing legislation that would harm its basic mission

- Coordinate national news media conferences to announce significant biomedical research discoveries

Goal: Provide adequate medical care for the poor and aged

- Interact with state Medicaid officials to promote understanding of the critical role of medical schools and their teaching hospitals in care for poor and medically indigent and adequate support for these medical services

- Work with appropriate organizations representing the aged and poor on health care issues

Goal: Protect the professional role of the physician as the key to quality care of the patient

- Raise the issue of maintaining the central role of the physician in medical care at the Council for Medical Affairs

- Seeks ways to foster a better collaborative relationship among physicians, nurses and other health professionals

Goal: Encourage socioeconomic and demographic diversity of medical students

- Continue special AAMC efforts for minorities and women

National Medical Research Month

Statement of Purpose

In a remarkable display of long-term cooperative effort involving federal funding and the intellectual capital of both public and private institutions, our country has developed a program of biomedical and behavioral research that is unexcelled throughout the world and enormously productive in human, social and economic terms. The rate of discovery of new knowledge about health and disease has increased dramatically, the ability to treat successfully both acute and chronic disease has been revolutionized and the contributions to other fields of science and technology have been extraordinary.

This invaluable national resource remains poorly understood, however, by many citizens as well as their political representatives in terms of its contributions, its capabilities, its limitations and the circumstances which permit it to flourish. Given the enormous potential for betterment of the human condition and the possibility of significant waning of popular support of the effort, it is proposed that a broadly based, carefully planned and executed effort be undertaken at both the national and local levels to enhance the public awareness and comprehension of the research enterprise throughout our society.

In specific terms, the activities could include the following:

- the designation of National Medical Research Month in early 1983 by either Presidential proclamation or a joint resolution of Congress
- the establishment of a broad base of sponsoring scientific societies and voluntary health organizations
- the development of a theme and logo and the preparation of appropriate information material for use at both national and local levels

- the development of events designed to both attract the public attention and inform the public about medical research, for example, Congressional hearings, radio and television talk shows, programs by and at the National Institutes of Health
- similar activities arranged and conducted by local institutions and organizations such as open houses, participation in radio and television programs, presentations to service organizations
- the recruitment of a group of prestigious individuals comprising a committee of sponsors

NATIONAL MEDICAL RESEARCH MONTH

Charge to the Steering Committee

The Association has decided to assume a leadership role to advocate the continuation of adequate public support for medical research and has established a Steering Committee to provide advice to the Association as it undertakes this responsibility.

Specifically, the Committee's advisory functions should encompass the following:

- the development and dissemination of an overall national strategy for assuring the most successful effort
- the identification of other organizations whose participation and support should be sought
- the identification of prominent lay and professional individuals whose cooperation should be sought through membership on a high-level committee of honorary "sponsors" of National Medical Research Month
- assistance in securing the designation of a National Medical Research Month by either Presidential proclamation or a joint Congressional resolution
- the development of a theme and logo that could be used both nationally and locally
- the preparation of generalizad data presentations and other background information appropriate to the national level, but useful to individual institutions and organizations in guiding or supplementing the development of locally appropriate material
- advice on the coordination at the national level of activities during the designated month

Medical Student Financial Assistance Questionnaire:

Preliminary Report

In early February 1982, the deans of all U. S. medical schools were asked to provide information about sources of student financial assistance. This survey was initiated in light of the Administration's FY 1983 budget request which proposes severe reductions in federal financial assistance programs available to medical students. The survey will allow the AAMC to serve as a broker of information about successful or promising approaches to student financial aid by requesting medical schools to provide information about steps taken to enhance existing or to develop new sources of funding to offer debt management counseling, to collect Health Professions Student Loans (HPSL), and to create cirricula time for employment opportunities for students.

While all responses have not yet been received and tabulated, the following innovative ideas and programs will serve as a preliminary report of the survey results. A formal report detailing survey results will be disseminated to the medical schools when all surveys are received and the information is collated.

I. Institutional Financial Assistance Programs Through Private Capital Sources

1. University of Kentucky College of Medicine

The class of 1970 Student Loan Fund was established by the College of Medicine's Class of 1970 as a genuine effort to provide financial assistance for medical students in the future. Alumni have been informed about the financial aid crisis and are concerned that aid sources are dwindling. Past graduates who were recipients of financial aid understand the importance of its availability.

The Class of 1970 Student Loan Fund is a newly established revolving loan and the first awards were made for the current academic year (1981-82- 7 awards total $5,000.00). All available cash, which was minimal due to the newness of the program, was invested by the University last fall in order to earn as much interest as possible. Loans are currently set at $1,000 per academic year which may be changed at a later date when more cash is available. The first awards were made to senior students in order to get the program moving as quickly as possible; senior students are quickest to enter repayment schedule. The objective of the program is to establish a perpetual loan program.

Funds were contributed on an individual basis. Contributions were pledged over a number of years, assignment of insurance policies, etc.

2. Medical College of Georgia

The Medical College of Georgia has instituted a Student Employment Program during the 1981-82 academic year. Eighty medical students were accepted into a program designed to train and employ students as nursing assistants in the intensive care unit. Students take a one month course in basic procedures before beginning work. Hours are flexible and adapted to the student's

schedule. Response has been most positive as a financing source, as a learning process, and as a means to address the nursing shortage. Academic progress is closely monitored to assure that work does not compromise academic success. Students earn $170/month which is provided by the hospital personnel budget.

3. Southern Illinois University School of Medicine

The Illinois Health Improvement Association, an association formed by rural families to promote health care in the State of Illinois, has as a goal to assist students financially who would eventually like to practice medicine in rural Illinois. The Association established a Medical Student Aid Fund to provide loans to SIU School of Medicine senior students who are in financial need and are from non-metropolitan areas of Illinois and who express an intent to enter primary care specialty and practice in a non-metropolitan area in Illinois. No interest is charged on the loan and the recipient has seven years to repay. Over the past five years, an average of 7 students each year have received loans totaling $15,000.

4. Dartmouth Medical School

At the beginning of the 1982-83 academic year, Dartmouth will initiate its Medical Education Loan Corporation (MELCO). MELCO is a loan program which will be financed through tax-exempt bonds allowing Dartmouth to lend to students at about a 12% interest rate. These loans feature a graduated repayment schedule with payments graduated relative to the income trends of graduates. Funds for MELCO will be secured through issuance of tax-exempt bonds. In addition, a sizeable start-up gift was received from a private doner. This gift will serve as front-end capital which, in today's bond market, will help to reduce interest charges. Although

MELCO's interest rate is dependent on the rate at which bonds are sold, interest rates will be lower than HEAL loans provided by Chase Manhattan. Also, the sale of tax-exempt bonds allows the public to "invest" in future physicians.

II. STATEWIDE OR MULTIPLE SCHOOL FINANCIAL ASSISTANCE PROGRAMS

1. Creighton University School of Medicine

Through the Nebraska Medical Association, Nebraska physicians have established the Nebraska Medical Foundation. These physicians believed it was their responsibility to help medical students with family residency in the state of Nebraska with financial assistance. Medical students are eligible for a Foundation loan after completing satisfactorily the first-semester of medical school. Eligible students' parents must be state residents of Nebraska. The maximum loan per academic year is $2,500 and, currently, the interest rate is 12% and accrues while the student is in school and residency. The student does have the option to delay any payment until residency is completed; however, students are urged to pay interest during residency if possible.

Students at the University of Nebraska School of Medicine - Omaha are also eligible for loans through the Nebraska Medical Foundation.

2. Bowman Gray School of Medicine of Wake Forest University

North Carolina has established a N.C. State Tuition Remission Fund to assist students with North Carolina residence status who are accepted to the private medical schools (Bowman Gray and Duke), but have a financial situation which might force them to enter a less expensive state supported school. The program provides a remission of a portion of tuition based on an individual student's financial need. Monies for fund are from the state based on a set amount per student up to 60 percent of the total enrollment.

3.	Consortium Schools	Stanford	Cornell	U of Chicago
		Columbia	Duke	Rochester
		Case Western	Harvard	Pittsburgh
		Yale	Washingon U	U of Pennsylvania
		John Hopkins		

The Kaiser Family Foundation offered the 13 private medical schools listed above a $50,000 scholarship grant if the school's alumni and friends matched it with an additional $150,000 in scholarship gifts. The Kaiser Matching Challenge was developed by the Foundation due to increasing debt burdents of medical students and an interest in having medical schools develop new approaches to fund raising. Schools responding to the survey note that through the Challenge, the medical community (students, parents, alumni) became more aware of financial problems of currently enrolled medical students.

4. The Medical College of Wisconsin and the University of Wisconsin Med School

The Wisconsin Health Education Assistance Loan (WHEAL) Program is a state version of the federal HEAL program, with the state of Wisconsin serving as the lender. During the 1981-82 academic year, students were able to borrow up to $15,000 (in 1980-81, annual limit was $10,000). Interest for the current year has been set at 14.75 percent, with a .25 percent insurance fee paybale in advance. All students enrolled in the state's two medical schools and the Marquette University Dental School are eligible to participate.

The original concept for the WHEAL Program included an "optional" service agreement that allows students to cancel a portion of their WHEAL loans in return for practice in a state shortage area. However, this is not a condition for eligibility. The state appears to believe that the WHEAL Program will provide needed funds for students as well as eventually meeting the practice needs of the state.

III. DEBT MANAGEMENT COUNSELING

Most medical schools offer some degree of debt management counseling, either formally and/or informally, individually and/or collectively. Some schools express frustration that their counseling opportunities are limited due to insufficient staffing, funding and time. The use of computers would improve the effectiveness of counseling at some schools.

Issues addressed during counseling sessions include: rights and responsibilities of borrowers, amount of debt, loan consolidation, repayment schedules, deferment, budgeting, specialty choice, credit, taxes, insurance, and investments. Some schools indicated interest in establishing formal debt management training programs, including issues in business aspects of medicine. One school hopes to initiate counseling sessions for parents of entering students.

Almost all schools offering counseling insit on "exit interviews" for graduating seniors. Periodic counseling throughout medical school is usually offered on a more informal basis. Many schools have developed written materials, some in manual/booklet form, in order to provide current financial aid information to medical students.

In addition, schools are developing programs to use experts outside the institution, who usually donate their time free of charge, such as bankers, accountants, and investment counselors, to provide the indebted medical student with financial advice.

IV. HEALTH PROFESSIONS STUDENT LOAN (HPSL) COLLECTION

Most medical schools report that responsibility for HPSL collection resides in the university, not the medical school. In response to the recent government review of HPSL delinquency rates and collection procedures,

some schools have transferred HPSL collection responsibility to the medical school and have implemented policies to improve debt collection.

Schools indicating success in HPSL collection efforts state that low delinquency rates are due to repeated personal contact with the borrower throughout medical school, effective "exit" interviews with graduating borrowers, the computerization of HPSL billings, and the use of collection agencies and legal action if the institution's efforts are unsuccessful.

For the improvement of HPSL collection, the schools repeatedly stressed the need for the involvement of the medical school in collection procedures, for more personnel, and for more time allotted to collection efforts. One major problem experienced by numerous schools was the inability to locate delinquent borrowers. In order to solve this barrier to loan collection, one school has enlisted the help of its alumni association to locate borrowers in particular cities and states.

V. EMPLOYMENT

Most medical schools either do not allow or do not encourage employment as part of the formal financial aid package. However, those schools that offer employment opportunities to medical students emphasize the importance of monitoring academic performance to that employment does not compromise the student's educational experience. In fact, some schools only offer work study positions which are educationally useful.

Several schools indicate that policy revisions and curricular restructuring are being considered to permit employment during medical school. For example, one school has delayed its starting date by two weeks in order to allow entering and second year students additional time for work. Another school is considering instituting a shared job opportunity program and an individual advancement program to shorten medical school for qualifying students. Other schools offer employment opportunities in the summer instead of during the academic year.

Roles for the Library in Information Management

The AAMC is about to complete a two-year study, sponsored by the National Library of Medicine, of the impact of new information technologies on the roles of libraries in the transfer of the recorded public knowledge base within academic health sciences centers (AHSC). A changeover from a paper-based to an electronic-based information system is occurring so rapidly in society that a serious academic information management problem is developing. The use of powerful electronic storage and retrieval technologies to make manageable the exponentially growing knowledge base of science and medicine (doubling every 4-6 years) requires equally sophisticated technological capabilities and specialized information management skills in AHSC.

The new technologies make essential the modification of traditional means for information storage transfer such as libraries and the development of different information use behaviors on the part of faculty, students and practitioners. The technology for the management of organizational information resources (hospital and medical information systems) and the management of the academic public recorded knowledge base (publication systems, libraries, faculty data files) are developing along parallel tracks which should be integrated into a network system if effective and efficient knowledge transfer is to occur.

Mini- and micro-computer systems in AHSC can link faculty, students and practioners more directly to the world knowledge base, but as more books, journals, and databases become accessible through computer terminals, a more

effective interface is needed. Information brokers will be needed to organize access to knowledge and to organize the information for effective use. Fresh knowledge for better decision making in research, clinical, educational and managerial settings is essential, and effective library systems that assure rapid, economical, organized information are crucial. The roles of libraries and librarians as information and knowledge managers, responsible for content as well are information forms, are accepted in industry as key elements in effective organizational use of information. AHSCs are ill equipped at this time to respond to the changes in the information environment that are in process. Its information handling systems are largely independent, incompatible, and unrelated to large institutional goals.

The study call for a reevaluation of the management of the vital flow of scientific and medical knowledge in AHSC, for the development of academic information resources management networks, and for its integration with other information systems to form an interactive inter-related information base for AHSCs. To accomplish this goal the study calls for a concerted collaborative effort, involving the professional associations and societies, federal agencies, industry and public and private foundations, to marshall the resources that will assist AHSCs to make the best information available through state-of-the-art technologies to support advances in science, medical education and health practice.

The project directors of the study are John A.D. Cooper and Marjorie P. Wilson. William D. Mayer is Chairman of the Advisory Committee which includes COD members Roy Schwarz and Thomas Miekle. Nina W. Matheson is the

principal investigator and author of the report which will be published in the fall as a supplement to the Journal and Medical Education.

The General Professional Education of the Physician and College Preparation for Medicine

The Association's project to study the general professional education of the physican and college preparation for medicine is under way. The project panel chaired by Stephen Muller, President of the Johns Hopkins University, (see page 30) held its first meeting in early January. At the meeting an overview of the general professional education of the physician and college preparation for medicine was reviewed. Subsequently, the Overview was sent to approximately 6440 individuals in the academic community (see page 29) to stimulate discussion. To generate responses to the Overview the questions raised in the document were incorporated into a questionnaire that could be torn out and returned to the project director. Over 800 were received in three weeks.

The responses, including the open ended questions, will provide the panel with a sense of the community's views. Eight institutions have requested additional copies of the Overview for their curriculum committees.

The panel is in the process of appointing three initial Working Groups. One is on essential knowledge, the second on necessary skills, and the third on personal qualities, values, and attitudes. Each group will be asked to examine these domains at each level from college preparation through medical school. Colleges, medical schools and societies will be asked to provide their views in writing to these groups. During 1983 the panel will hold hearings in each of the four AAMC regions.

From the outset the AAMC undertook this project to stimulate discussion and candid examination of the general professional education of the physician and college preparation for medicine by institutions and their faculties. The success of the project will depend upon the degree tc which each institution becomes involved.

Distribution

"Overview Document" (and Questionnaire)

February 19, 1982

Group		Number
1.	Presidents of four-year colleges/universities that supply medical students	819
2.	University vice-presidents for medical/health education	75
3.	U.S. and Canadian medical school deans (members of AAMC Council of Deans)	159
4.	Directors, teaching hospitals (members of AAMC Council of Teaching Hospitals)	475
5.	President and two official representatives of AAMC Council of Academic Societies	225
6.	AAMC Organization of Student Representatives	140
7.	Members of AAMC Group on Medical Education with designated interest in (a) research in medical education, (b) undergraduate education, (c) graduate education, (d) continuing education, and (3) teaching hospital-based educational program researchers and/or coordinators	1,099
8.	U.S. and Canadian medical school Basic Science Department heads	941
9.	U.S. and Canadian medical school Clinical Science Department heads	1,885
10.	U.S. medical school teachers who received "outstanding teacher awards" in 1980 and 1981 (as reported by their deans)	400
11.	Group on Student Affairs	225
		6,443

Roster

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Project on the General Professional Education
of the Physician and College
Preparation for Medicine

Panel Members

Steven Muller, Ph.D., Chairman; President, The Johns Hopkins University and The Johns Hopkins Hospital

William P. Gerberding, Ph.D., Vice-Chairman; President, University of Washington

David Alexander, D.Phil., President, Pomona College

John S. Avery, M.D., Practicing Internist, Boulder, Colorado

Paula J. Clayton, M.D., Professor and Head, Department of Psychiatry, University of Minnesota Medical School, Minneapolis

John W. Colloton, Director, The University of Iowa Hospitals and Clinics; and Assistant to the President for Statewide Health Services

James A. Deyrup, Ph.D., Professor of Chemistry, University of Florida

Stephen H. Friend, M.D., Ph.D., Resident in Pediatrics, Children's Hospital of Philadelphia, University of Pennsylvania School of Medicine

John A. Gronvall, M.D., Dean and Professor of Pathology, The University of Michigan Medical School

Robert L. Kellogg, Ph.D., Dean, College of Arts and Sciences, University of Vir

Victor R. Neufeld, M.D., F.R.C.P. (C), Professor of Medicine and Director, The M.D. Programme, Faculty of Health Sciences, McMaster University

David C. Sabiston, Jr., M.D., James Buchanan Duke Professor of Surgery and Chairman, Department of Surgery, Duke University Medical Center

Karl A. Schellenberg, M.D., Ph.D., Professor and Chairman, Department of Biochemistry, Eastern Virginia Medical School

Robert T. Schimke, M.D., Professor and Chairman, Department of Biological Sciences, Stanford University

Lloyd H. Smith, Jr., M.D., Professor of Medicine and Chairman, Department of Medicine, University of California, San Francisco, School of Medicine

Stuart R. Taylor, Ph.D., Professor in Physiology and Pharmacology, Mayo Medical School and Graduate School of Medicine, University of Minnesota, Rochester

Daniel C. Tosteson, M.D., Dean, Faculty of Medicine, Caroline Shields Walker Professor of Physiology, Harvard University; and President, Harvard Medical Center

Burton M. Wheeler, Ph.D., Professor in English and Religious Studies, Washington University, St. Louis

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

For the past several years the Society has sought to develop closer relations with the Council of Deans and the AAMC. In 1979 and 1980, the Chairman of the Council accepted an invitation to appear at the Society's annual meeting. The Society used these occasions to seek additional avenues of collaboration between the two organizations. The COD Administrative Board responded with the suggestion that there be a jointly sponsored program session held in conjunction with the 1981 AAMC annual meeting. This suggestion was adopted and on November 1st a program on "Information Technology: Implications for Medical Education" was offered. The speakers included Donald A.B. Lindberg, M.D., Martin M. Cummings, M.D., Phil R. Manning, M.D., and M. Roy Schwarz, M.D.

On Tuesday afternoon, November 3rd, the Chairman, Chairman-Elect, and the Immediate-Past-Chairman of the Council met with the Executive Committee of the Society. The event stimulated a rather frank exchange of views regarding objectives of the Society in forming and maintaining itself as an autonomous organization. The rather clearly enunciated objective of the Society, as expessed by its leadership, is to enhance the position of continuing medical education and CME program directors at both the local and national levels. It became evident that the Society believed that its organization is meeting these objectives in at least one primary respect: its very existence appears to be having a forceful impact in gaining the attention of the AAMC. This success in no way persuades the Society that it is appropriate to consider its own desolution in favor of pursuing their professional development activities as part of the AAMC's Group on Medical Education.

At the conclusion of the meeting, the Society's Executive Committee distributed two documents as examples of the work product of the Society. They are "Essentials for Medical College Continuing Medical Education" and "SMCDCME" Goals and Objectives for the 1980's", enclosed on the pages provided. They invited the review of these documents by the COD.

BACKGROUND

In March 1976 the Luginbuhl Task Force of CME recommended to the Executive Council that the AAMC initiate our activities in the area of CME by:

1. Appointing an ad hoc committee on CME
2. Allocating some staff and resources to CME associated activities
3. Establishing a group on CME

The first two recommendations were accepted and implemented in the summer of 1976 while a special interest group on CME was established within the GME in lieu of creating a new group for continuing medical education. Therefore, the CME interests and activities were encompassed within the GME scope.

At the same time, March 1976, from informal gatherings of the CME directors held annually, a formal society was established. This society was created at that time despite the fact that the gathered group was informed of the concurrent developments at AAMC. As a consequence, each medical college director (or the majority of them) now belonged to two different groups with

identical membership, namely the CME component of the Group on Medical Education and the Society of Medical College Directors of CME. Since the creation of this Society, AAMC staff and the GME have made efforts to establish a constructive relationship with the Society, predominantly through the planning of programs for the annual meeting of the GME and the regional meetings held in the spring. One drawback has been that only a few CME directors attend the GME regional meetings in spring because the SMCDCME holds its annual meeting regularly in spring at an attractive place.

Programs of the SMCDCME usually focus on issues peculiar to continuing medical education, e.g. adult learning, self-directed learning, management of a CME office, relationship to other organizations, research in CME, needs assessment and evaluation, accreditation. In addition, several task forces were appointed to develop recommendations to the Society regarding research, the role of CME in the medical school, essentials and goals for the Society. The latter task force report consists of two documents which were adopted by the Society in May of 1981. They were to serve as a stimuli to increase the quality of continuing medical education efforts in medical schools, but they can also be viewed as being aimed at putting pressure on the individual CME director to conform with general requirements for providing CME in his medical school. It is important to note that the Society's Essential and Goals have no relationship whatsoever to the Essentials of the ACCME.

Over the past few years the AAMC has been engaged in various activities relative to CME. Some of them are:

- Ad Hoc Committee on CME appointed in July 1976, the committee sponsored several studies and presented a final report to the Executive Council in September 1979 (Exhibit 1,2,3,4).

- CME program at each annual meeting since November 1977, sponsored by the GME and in cosponsorship with the SMCDCME since 1979.

- Active participation as a major driving force, in the LCCME and later the ACCME

- Initiation of a long term project on developing criteria for quality in CME. This is a collaborative project with the Office of Academic Affairs of VACO and is sponsored under the VA's EMI granting authority. This project has developed a set of criteria that presently are being incorporated into the Essentials and Handbook of the ACCME (5). The project is collaborating with several constituent institutions in field testing the use of the criteria for program planning and implementation.

- Staff input and participation in SMCDCME meetings.

In November 1980 and 1981 on the occasion of the Annual Meeting, the officers of the COD Administrative Board met with the officers of the SMCDCME upon request by the SMCDCME. At the first meeting it was agreed to organize a joint session for the 1981 annual meeting. The session was held on Monday evening during the Annual Meeting on the topic of "Information Technology: Implications for Medical Education". It attracted a large audience from the Council of Deans and from the Society.

The Administrative Board discussed the Essentials at its meeting of January 21, 1982, and felt that the matter should be brought before the entire Council of Deans at the spring business meeting.

Issue

- What should be the nature of the relationship between the AAMC and the SMCDCME?

"Essentials for Medical College Continuing Medical Education"

A Statement of

The Society of Medical College Directors of Continuing Medical Education

The Society of Medical College Directors of Continuing Medical Education (SMCDCME) recognizes that the education and training of physicians for patient care extends through a continuum of undergradudate, graduate and continuing medical education during a life-time of medical practice. The Society believes that the medical colleges of the United States have educational, research and service responsibilities in each of the three segments of this continuum. The Society considers the following to be essentials if a medical college is to fulfill its responsibility in continuing medical education (CME).

This list of essentials is a product of careful consideration of medical college CME by many members of the Society over a period of more than two years. It is presented in the expectation that, to the extent these essentials are fulfilled, the medical college will benefit as will its physician constituents in practice and the patients they serve. The Society recommends these essentials as appropriate minimum standards for the CME component of medical college accreditation.

In this document each essential is stated and accompanied by a brief explanation.

Essential #1

There must be an identifiable unit, office or department that has overall responsibility for the development and management of the entire CME program.

This essential speaks for itself. Without such a locus of overall responsibility, the CME effort of the college becomes uncoordinated and diffuse, and does not thrive.

Essential #2

An institutional commitment to excellence in CME is essential.

The institutional commitment to excellence in CME should be at the same level as its commitment to excellence in other teaching, research or service activities. There should be evidence that this is indeed the case.

Essential #3

A genuine faculty commitment to CME is essential.

There should be explicit expectations that faculty members will participate at an appropriate level of performance in the CME activi-

ties of the college. There should be formal recognition of faculty participation in the CME activities of the college with identifiable recognition for academic advancement, remuneration, and other incentives.

Essential #4

There must be a substantial focus on the physician as a self learner.

Self-assessment should be developed and taught at the undergraduate and graduate level as well as in the individual practice situation. Medical college CME should be able to assist a physician to develop learning skills he or she uses best and be able to respond to an individual physician who has identified his or her own needs or goals for rendering quality care.

Essential #5

Research related to continuing medical education is an essential CME activity in a medical college.

CME divisions or departments should conduct (1) program research to improve existing CME activities or to develop new ones, and (2) conduct research related to understanding the process of CME. There should be a budgetary designation for research and development. Administrative support is necessary. There should be research design and implementation capabilities, and the means to apply research conclusions to CME.

Essential #6

CME programs or activities must promote the medical college as a central resource for up-to-date information needed for excellence in patient care.

Medical colleges are repositories of medical knowledge with societal obligation and accountability to preserve, enlarge and transmit this knowledge base. Up-to-date information needed for excellence in patient care should be promptly available to practicing physicians. Medical college CME can serve as a role model for various learning approaches, such as, for example, a systematic curricular approach for its referral area.

Essential #7

It is essential that CME be a realistic competitor for medical college resources.

A medical college's commitment to CME is ultimately measured by the fiscal support provided to foster growth and excellence in this

area of institutional activity. While resources for basic and clinical research, patient care and the education of medical students and trainees are of high priority, CME should also be regarded as a realistic competitor for funds and resources. As minimal evidence of this commitment, the medical college CME program should have an annual core budget for basic support that is developed with regard to its total obligations, as distinct from the fiscal needs of individual program activities.

Adopted at annual meeting, Columbus, Ohio, May 19, 1981

"SMCDCME Goals and Objectives for the 1980's"

The Society of Medical College Directors of Continuing Medical Education

These SMCDCME goals and objectives for the 1980's, together with the suggested processes for accomplishing them, should provide the Society with an instrument to help achieve its members' aspirations for the advancement of continuing medical education within the medical colleges of the nation.

The goals and objectives are the result of more than two years of discussion, review and comment by the membership of the Society, adoption in principle at the 1980 Fall Meeting, and then a final rewording by six mini-task forces, which also prepared the suggested processes or steps which might be taken to move toward each of the stated objectives. Evaluation of the process or the progress made toward reaching the objectives could be part of the agenda at future meetings.

GOALS

Six goals are adopted as follows:

Goal I Establish CME as an integral part of the mission of a medical college along with undergraduate medical education, graduate medical education, and research.

Goal II Establish medical college CME as the primary segment in the continuum of medical education that fosters close interactions and exchange between academia and the community practice of medicine.

Goal III Strengthen the medical college as a major CME resource for physicians in practice.

Goal IV Establish research activities relevant to CME and strengthen them such that they become recognized as legitimate scholarly activities within the setting of an academic medical center.

Goal V Establish SMCDCME as a focus or forum for cooperation in developing policies for enhancing CME activities of medical colleges and for coordinating CME activities.

Goal VI Enhance the leadership role of SMCDCME in the development and implementation of CME standards, departments and programs in medical colleges, professional societies and other recognized organizations which seek to provide or influence CME.

OBJECTIVES AND SUGGESTED PROCESSES

Goal I Establish CME as an integral part of the mission of a medical college along with undergraduate medical education, graduate medical education, and research.

Objective #1 Achieve incorporation of SMCDCME "Essentials for Medical College CME" into the criteria used by the LCME in the accreditation of medical colleges and into the criteria used by the ACCME in the accreditation of medical college CME programs.

Suggested Process Steps to achieve Goal I, Objective #1:

a) All members of SMCDCME should agree to adhere to the Essentials and to obtain acceptance of them by their respective administrations and faculties.

b) A task force of SMCDCME members should prepare a set of examples illustrating the application of the Essentials to a medical school CME program, and the institutional CME program to its undergraduate and graduate programs.

c) A task force of SMCDCME members should compare the criteria and data-gathering forms used by LCME and ACCME with the SMCDCME "Essentials."

d) SMCDCME should request the incorporation into the criteria of the LCME review process of SMCDCME's "Essentials for Medical College CME."

e) SMCDCME should request the incorporation of its "Essentials for Medical College CME" into the ACCME accreditation process in respect to medical college CME programs.

Objective #2 Develop guidelines to assist medical colleges to implement SMCDCME "Essentials."

Suggested Process Steps to achieve Goal I, Objective 2:

a) Form a task force to develop guidelines, examples of their implementation, and measures to assess whether the essentials have been realized (extension of enabling objective I.1.b).

b) Submit guidelines, examples and evaluation measures to their respective and appropriate medical college administrative and faculty persons and committees for local approval and implementation.

c) Members should submit guidelines, examples and evaluation measures to their respective and appropriate medical college administrative and faculty persons and committees for local approval and implementation.

Objective #3 Establish a written policy in each medical college stating that each faculty member has a responsibility to contribute appropriately to the institution's CME program, that these contributions will be considered for promotion and tenure equally with contributions to undergraduate and graduate teaching and research, and that the institution will provide the structure and support to achieve these purposes.

Suggested Process Steps to achieve Goal I, Objective #3:

a) Obtain existing policy statements from the Society membership.

b) Identify the ways in which these policies have been adopted and implemented.

c) Develop a model statement, including rationale and suggested methods of implementation.

d) Work within AAMC through its administration and committee structure to have CME accepted as an institutional responsibility.

Goal II Establish medical college CME as the primary segment in the continuum of medical education that fosters close interactions and exchange between academia and the community practice of medicine.

Objective #1 Develop and promote self-learning, self-assessment and communication skills at all levels of the continuum.

Suggested Process Steps to achieve Goal II, Objective #1:

a) Include the development of self-learning, self-assessment and communication skills in Society research activities.

b) Within the individual colleges of medicine seek to place greater emphasis on self-learning, etc.

c) Design curricula to include self-assessment techniques and instruments.

d) Encourage documentation of experiences as techniques for reassessment.

Objective #2 Modify undergraduate curricula and post-doctural training to inclu educational needs identified in CME.

Suggested Process Steps to achieve Goal II, Objective #2:

a) Involve practitioners on curriculum committees.

b) Develop student participation in practice sites as a dependable part of the curriculum.

c) Seek to attain inclusion of CME directors/faculty in medical school Curriculm and Executive Committees and Heads-of-Departments meetings.

d) Develop attitudes in the medical schools which recognize medical education as a continuum that includes medical college, postgraduate training and continuing education.

Objective #3 Develop SMCDCME position statement dealing with CME as the final and longest segment of medical education.

Suggested Process Steps to achieve Goal II, Objective #3:

a) Appoint a committee to write the statement.

b) Present statement to executive committee for modification or approval prior to presentation to Society membership.

c) Presentation to Society for rejection or ratification.

Goal III Strengthen the medical college as a major CME resource for physicians in practice.

Objective #1 Encourage medical colleges to collaborate with specialty societies and other providers of continuing medical education to urge and develop practice-oriented curricula for various specialties, considering the various and individual needs of practitioners in terms of knowledge, skills and competence.

Suggested Process Steps to achieve Goal III, Objective #1:

a) A medical college or group of medical colleges should be designated to work with each specialty society to define competencies appropriate for the specialty and outline mutual objectives in the continuing education of members of the respective groups.

b) The findings regarding competencies and objectives should be disseminated to all medical colleges.

c) Self-assessment tests (including performance tests) should be developed to enable individual practitioners to determine mastery of designated competencies.

d) Medical colleges should offer their faculties a series of workshops on educational methods.

e) The Society should develop and disseminate to medical colleges a directory of resource persons with recognized skills in adult education methods.

Objective #2 Promote immediate-response consultation opportunities for practitioners, utilizing the telephone and/or other appropriate communication and response systems.

Suggested Process Steps to achieve Goal III, Objective #2:

a) Encourage medical colleges that provide telephone consultation services to conduct research on the effectiveness of the service with special reference to comparisons of similar groups of physicians using and not using the service. This information should then be made available to colleges of medicine.

b) Members should inform and seek the support of key department chairpersons regarding a well-organized immediate-consultation service.

c) Make persons in leadership positions in hospitals aware of the possible referral advantages of an immediate-consultation service, utilizing appropriate communication modes.

d) Establish dialogue regarding immediate-consultation services with the appropriate local and regional organizations and institutions to enhance effectiveness and avoid conflict and overlap.

Objective #3 Develop the medical college data base as a more effective resource for continuing medical education.

Suggested Process Steps to achieve Goal III, Objective #3:

a) Arrange periodic regional conferences of medical college educational support services to plan joint research projects on effective teaching and learning methods. (The Group on Medical Education of the AAMC would also be a resource.)

b) Offer a series of workshops on adult educational methods for appropriate medical college faculty and CME personnel.

c) Develop methods and programs to utilize the vast repository of knowledge of the basic sciences available in medical colleges, with particular emphasis on clinically relevant forms for practitioners.

d) The medical college should provide leadership in developing and implementing a regional assessment of CME needs in order to more effectively utilize the data base and resources of the medical college.

e) The medical college educational and data base and resources should be made more readily available to practicing physicians through dissemination of information on library resources and other educational opportunities. Access to these should be simplified through appropriate arrangements and amenities.

Goal IV Establish research activities relevant to CME and strengthen them such that they become recognized as legitimate scholarly activities within the setting of an academic medical center.

Objective #1 Encourage program research to improve existing CME activities, basic CME research, and research appropriate to newer technology.

Suggested Process Steps to achieve Goal IV, Objective #1:

a) Expand the activities of the Research Committee and promote collaborative research through this committee.

b) Develop a research consortium or clearing house to record, catalog and distribute information to interested investigators.

c) Publish a directory of on-going research activities among the members.

d) Organize or sponsor workshops on CME research to review existing efforts, develop strategies to implement valid methods, and learn about sophisticated methodology and research tools from experienced researchers in a variety of disciplines. Workshops could be held in conjunction with Society meetings.

Objective #2 Bring the academic, monetary and administrative resources of medical colleges and their universities to bear in order to promote and accomplish research in CME.

Suggested Process Steps to achieve Goal IV, Objective #2:

a) Produce a position paper emphasizing the importance of CME research, the need for support in terms of academic resources, fiscal resources, and faculty collaboration.

b) Exert pressure via the Society's association with AAMC to have Deans recognize the need for, and support the efforts in, CME research.

c) Have the Society act as a repository of information regarding successful efforts to obtain the resources of medical colleges.

Objective #3 Identify existing funding sources for support of research and development and make an effort to identify new sources.

Suggested Process Steps to achieve Goal IV, Objective #3:

a) Publish summary of research support already in existence, possibly by polling membership.

b) Organize a directory of funding sources.

c) Develop several cooperative projects that might have more appeal to funding agencies.

d) Exert pressure (via AAMC) on Medical College Deans to separate CME research from programming and support this research effort with "solid money."

Goal V Establish SMCDCME as a focus or forum for cooperation in developing policies for enhancing CME activities of medical colleges and for coordinating CME activities.

Objective #1 Identify the special qualities of medical college CME that make it superior, describe these qualities, demonstrate they exist and promote them.

Suggested Process Steps to achieve Goal V, Objective #1:

a) Appoint a committee to work on this objective (include Directors of the best programs in the country, basic scientists, clinical staff, professional educators, curriculum committee members).

b) Develop a questionnaire that

   a) would help CME Directors identify strengths and weaknesses in their own programs.
   b) objectively measure areas of success and/or improvement in CME.

c) Conduct programs at SMCDCME meetings to promote these important qualities.

d) Promote through AAMC and ACCME the superior qualities of medical college CME.

Objective #2 Establish regional meetings for coordination and cooperation on the programming of CME activities.

Suggested Process Steps to achieve Goal V, Objective #2:

a) Identify regions.

b) Organize regional committees (include an SMCDCME executive committee member).

c) Schedule a minimum of one meeting per year of medical schools within each region.

d) Have one medical school within the region serve as a clearing house to avoid duplication and achieve balanced programming.

e) Identify ways to coordinate, cooperate, evaluate and share successful practices as well as difficulties.

f) Include at regional meetings the Directors of Medical Education who work in hospitals of the region.

g) Establish a newsletter.

h) Develop a loose-leaf notebook for members on planning, administering and evaluating CME.

i) Develop a regional calendar.

Objective #3 Maintain a loose-leaf annually-updated document on current SMCDCME policies.

Suggested Process Steps to achieve Goal V, Objective #3:

a) Compile a list of specific SMCDCME policies.

b) Update the list annually.

c) Initiate collection of CME policies of medical colleges, then collate the data for the regions and then the nation.

d) Expand the document to include facts and figures on resources, faculty, protocol, etc.

Goal VI Enhance the leadership role of SMCDCME in the development and implementation of CME standards, departments and programs in medical colleges, professional societies and other recognized organizations which seek to provide or influence CME.

Comment: If Goals I-V and their accompanying objectives are accomplished, Goal VI, which addresses "Leadership Status for SMCDCME," will have been essentially achieved. Two additional objectives seem appropriate, however.

Objective #1 Establish a working relationship with selected other national organizations in the field of CME.

Suggested Process Steps to achieve Goal VI, Objective #1:

a) Identify other organizations in the field of CME.

b) Assess current membership involvement with these organizations.

c) Develop strategies for participation and responsible cooperative action with other organizations.

d) Develop membership or institutional participation in other organizations wherever possible.

Objective #2 Identify and assist members with interest and potential for leadership.

Suggested Process Steps to achieve Goal VI, Objective #2:

a) Support members currently seeking ascension in professional organizations, e

b) Encourage professional development of current and related staff by attending workshops, holding exchange visits, making program comparisons, et

c) Maintain communication among members to identify potential directors and assist in their placement, both colateral and upward.

d) Establish a committee of people with known leadership achievements to outline "how they did it."

e) Utilize workshops at national meetings as adjuncts to various plenary sessions and foster development and communication by way of newsletter items of interest to the membership.

Adopted at annual meeting, Columbus, Ohio, May 19, 1981

Request for a New-Data Collection and Reporting Activity

Dr. John Henry, Dean of Georgetown University School of Medicine has expressed his interest in having the AAMC collect and report departmental data in more detail than is presently available from the Liaison Committee on Medical Education Annual Financial Questionnaire. Recognizing the fact that this would increase the reporting process and the magnitude of the data input, Dr. Henry suggests that it would be an appropriate agenda item for the Council of Deans Meeting. His letter is attached.

GEORGETOWN UNIVERSITY
SCHOOL OF MEDICINE
3900 RESERVOIR ROAD, N.W.
WASHINGTON, D.C. 20007
(202) 625-7633

OFFICE OF THE DEAN

February 25, 1982

John A. D. Cooper, M.D., President
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, DC 20036

Dear John:

Thank you for your letter of November 30, 1981 in which you expressed the Association's interest in pursuing the possibility of deriving departmental data in more detail than is presently available from the Liaison Committee on Medical Education Annual Financial Questionnaire (LCME AFQ). In this regard, I would like to convey to you that there is considerable interest among medical schools for information on the sources of funds supporting the activities of the individual departments similar to the information now shown on Pages 1 and 2 of the questionnaire for the medical school as a whole.

Recently, during our budget preparation period, Dartmouth requested Georgetown University data regarding funding. I have also initiated similar requests for information from other medical schools. Therefore, I feel it is apparent that schools would find the information helpful in assessing the best allocation of funds to departments in comparison with other institutions. If these data were first collected in the AFQ and then inserted into the Institutional Profile System (IPS), the ease with which the statistics would be made available to constituents would be greatly facilitated.

I am aware of the tremendous detail involved, and, therefore, it might be best to concentrate first on the individual sources of the "hard"--unrestricted funds--by department. In other words, the sources listed on Page 1 of the AFQ, Columns A and D, would capture the data we are seeking. (Subsequently, the information in Column B--restricted funds--might also be collected.

I expect to discuss the feasibility of such a project with my colleagues of the Council of Southern Deans at the Council of Deans meeting in the end of March. Perhaps a similar discussion would be an appropriate agenda item for the national Council of Deans meeting.

John, I am fully aware of how this would increase the reporting process as well as the magnitude of the data input. But with the current stringent fiscal situation, the need for comparative data in this area is so great that your favorable consideration of the Association's assistance would be greatly appreciated. I look forward to discussing this with you further.

Sincerely,

John Bernard Henry, M.D.
Dean

JBH:rgp

V. A. Faculty Retirement: A Proposal

The University of Miami School of Medicine has developed a proposal to permit faculty members paid in part by the Veterans Administration to have their entire compensation--including the V.A. portion--considered eligible for treatment under Section 403(b) of the Internal Revenue Code. This is the provision that permits the employees of certain tax exempt organizations to purchase tax deferred annuities (i.e., TIAA-CREF). Since this will apparently require a revision of the tax code, Dr. Fogel, Vice President and Dean (Interim) would like to bring this matter to the attention of the Council of Deans. He writes, "During the development of a new retirement program at the University of Miami School of Medicine, it was pointed out by our V.A. faculty that serious inequities might exist between full-time faculty at the University and individuals who are University faculty members but also paid by the V.A. Hospital. Apparently this inequity has been there for some time but has been increased by the recent changes in federal law. Thereby the V.A. physician only returns a partial year of retirement unless he is 8/8ths.

In order to alleviate inequity, we decided to have the faculty memeber endorse his check over to the University of Miami and then provide a single check in which the faculty member would receive one retirement check as well as be eligible for benefits under 403B of the I.R.S. code. Before proceeding to implement such a program, we ask for a ruling from the Internal Revenue Service. Thus far, we have not received a ruling and it is doubtful that we would receive a positive ruling for many cogent reasons.

We then decided that it might bring greater equity if, for purposes of tax sheltering, individuals who were employed by the V.A. Hospital and were also members of the faculty of University of Miami could have their total salary (i.e. University salary plus V.A. salary) considered as one for purposes of the 403B

ruling. Our recommendation to Dr. Custis and his colleagues was that the AAMC, the VAH and, if appropriate, individual institutions seek to amend the legislation dealing with 403B sections of the IRS code.

I agreed to provide some examples of how these inequities exist. Mr. Siegel was kind enough to develop a few of these examples at the Assistant, Associate and Professorial ranks in Medicine and Surgery. In addition, we are asking our actuaries to come up with some specific data on individuals that we will present anonymously at that time. Unfortunately, this data will not be ready until the end of this month so it could not be included in a handout sent in advance."

Ad Hoc Committee on the Promotion of Ethical Standards in Research

At its most recent meeting, the Executive Council authorized the appointment of an AAMC committee to address broad ethical issues in the research enterprise. The membership of the committee is listed on the page following; the committee's charge is set out below:

ETHICS COMMITTEE CHARGE

Confidence in the personal integrity of scientists and in the quality of their work is imperative if scientific progress is to continue. Revelations of fraudulent research and the maltreatment of animal or human research subjects have recently received wide publicity. Unless accorded serious attention, this may lead to an erosion of public confidence in the honesty and integrity of the biomedical research community. The result might be a reduction of public willingness to invest in research, increased skeptism as to the validity of research results, and governmental efforts to police research.

The ad hoc committee on the promotion of high ethical standards in research should consider:

1. how institutions can assure and promote ethical conduct in laboratory and clinical research.

2. how institutions can effectively respond to suspicions of misconduct in order to ensure prompt action when problems are found to exist and prompt clearance of the scientists in question when suspicions are unfounded.

3. the responsibility of institutions to disseminate information about incidents of misconduct to other institutions, to research sponsors, and to the public at large.

4. the responsibility of senior investigators in assuring the validity of research data reported by junior colleagues.

5. the role of journal editors when the plausibility of findings presented in a paper is in question.

6. the steps that need to be taken to demonstrate to the public that the research community does require adherence to high ethical standards, that an effective system for the detection of misconduct exists, and that it can police itself.

It should be emphasized that the committee is being asked to address the broad ethical issues in the research enterprise and should not deal with the specific instances of misconduct in research.

Ad Hoc Committee on the Promotion of Ethical Standards in Research

Julius R. Krevans, M.D.
Dean
University of California, San Francisco
School of Medicine

James W. Bartlett, M.D.
Medical Director and Associate Dean
for Clinical Affairs
The University of Rochester
School of Medicine and Dentistry

Stuart Bondurant, M.D.
Dean
University of North Carolina
at Chapel Hill School of Medicine

David Brown, M.D.
Professor
Department of Lab. Med./Path./Ped.
University of Minnesota Medical School

Nathan Hershey, Esq.
University of Pittsburg
Health Services Administration

Robert Hill, Ph.D.
Chairman
Department of Biochemistry
Duke University Medical Center

Harold Hines, Jr.
President
Ryan Insurance Group, Inc.

Arnold S. Relman, M.D.
Editor
New England Journal of Medicine

LeRoy Walters, Ph.D.
Director
Center for Bioethics
Kennedy Institute
Georgetown University

A Young Scientist to be Named

3/10/82

Regional Institute On Geriatrics and Medical Education

Last June the Association's Executive Council authorized staff to undertake several activities to increase the Association's involvement in geriatric medicine as it related to the educational process. As a result, the AAMC sought and received grants from the Pew Memorial Trust and the National Institute on Aging for a series of four Regional Institutes on Geriatrics and Medical Education.

The Steering Committee for this project, under the chairmanship of Joseph E. Johnson III, M.D., Chairman of Medicine at Bowman Gray School of Medicine, and with the assistance of Eugene Stead, M.D., Professor of Medicine Emeritus at Duke Hospital, and Harland Wood, Ph.D., Professor of Biochemistry at Case Western Reserve University School of Medicine, has now developed a draft set of learning objectives and performance characteristics which can be used by medical education programs to evaluate and assess their effectiveness in incorporating pertinent material on geriatrics in their curricula. This document will be introduced at the Regional Institutes scheduled for April 22-23 in Chicago, May 20-21 in Philadelphia, June 3-4 in Atlanta, and June 17-18 in Salt Lake City. The document, as revised by participants at the Regional Institutes, will be presented in final form at a special general session of the Association's 1982 annual meeting. The Regional Institutes will also feature plenary session presentations on the incorporation of geriatric content in the basic biomedical and clinical sciences and small group discussion sessions on particular problems and approaches to geriatric medicine education that have been used by our medical schools.

Participants in these invitational conferences will include medical school deans; teaching hospital administrators; chairmen of basic science departments; chairmen and senior faculty of departments of internal medicine, family medicine, psychiatry, and other clinical disciplines with strong involvement in treating geriatric patients; faculty with curriculum development responsibilities; and some faculty with a special interest in geriatrics.

AAMC Clinical Evaluation Project

Data Bank

The final report on Phase I of the AAMC Clinical Evaluation Project is now being prepared. Beginning in 1978, information has been gathered from clinical faculty regarding practices and problems in evaluating the performance of clerks as they rotate through their core clerkships. Faculty from approximately 500 departments of internal medicine, pediatrics, surgery, psychiatry, obstetrics-gynecology and family medicine responded to a written request for an overview of their current evaluation process: instruments used, problems encountered, solutions attempted. During this period, AAMC staff have site-visited 12 institutions to form a perspective from which the survey information can be interpreted.

Although some of the information has been computerized, usual statistical summaries are not the most meaningful way by which to examine the collected data. Rather, the assembled protocols for the 500 departments are best summarized through a "content analysis" aimed at identifying overarching themes recurrent in clinical evaluation as well as timely issues of more "reliable" and "valid" rating forms. The recurrent concerns and dissatisfactions with the evaluation process, however, seem to focus not as much on the method of collecting and recording information, but on the limitations of the sources of information and on the purposes for which the information is used.

The forthcoming report will present such an analysis and synthesis of the data collected on the evaluation of clerks. An article on the evaluation of residents has been submitted to the JME. The article contains a synthesis of the information on residents that 357 departments included with their responses to the formal request on data for clerks.

The information is organized into a Clinical Evaluation Data Bank tailored to the needs of 1) clinical faculty involved in the evaluation of the performance of clerks and/or residents and 2) researchers in Offices of Medical Education who are responsible for developing systems or tools of evaluation. An outline of the contents of the databank is attached (Attachment 1). With the use of the databank, such persons will be able to draw upon experiences of departments with similar evaluation practices or with already developed evaluation systems that they may be contemplating. The databank will also be used to bring together clinical faculty who have identified common evaluation problems in order to develop specific strategies for dealing with such problems. It is anticipated that this approach will lead to the identification of various types of evaluation settings within which different evaluation methods may be applicable.

For further information, please contact Xenia Tonesk, Ph.D., Director, AAMC Clinical Evaluation Project (202-828-0561).

Attachment 1

CONTENTS OF THE AAMC CLINICAL EVALUATION DATABANK: CLERKSHIP*

A. Clerkship information for each department responding to the survey

1. Length of clerkship
2. Objectives of the clerkship
3. Responsibilities of the clerk
4. System of grading in the clerkship
5. Composition of the clerkship grade, e.g., percent determined by ward evaluation
6. Number and type of evaluation forms used in assessing the clerk rotating through the core clerkship
7. Methods other than evaluation forms used in assessing the clerk, e.g., oral exam, computer-based simulations
8. Provision for feedback to the clerk prior to final evaluation
9. Process by which final evaluation of clerk is determined
   a) Number of persons contributing independent information about the clerk
   b) Autocratic versus a democratic process in arriving at composite ratings
10. Role of clerk as evaluator
11. Content areas of evaluation, i.e., skills, personal qualities, etc. being evaluated via the evaluation tools used by the department
12. Problem areas identified by the department
13. Types of evaluation materials supplied by the department
14. Satisfaction with current evaluation process

B. Information on the administration of each clerkship form used by each department in evaluating the clerk

1. Position of persons completing the evaluation form, e.g., resident, attending
2. Level of acquaintance of evaluator with the clerk
3. Setting in which the evaluation form is used, e.g., inpatient
4. Presence of review system for evaluation form
5. Student role in use of form information, e.g., student required to sign after discussion
6. Use of form information within and outside the Department, e.g., Dean's office; confidentiality issue

---

* Where possible, the same information has been coded for departmental house officer evaluations.

C. Information pertaining to the structure of each clerkship form used by each department in the evaluation of the clerk

1. Composition of form, ranging from totally narrative to totally objective
2. Role of "Comments Section" on a partially objective form, e.g., required only when extreme positive or negative evaluation is indicated
3. Presence of a "set" with which the evaluator is to assess the clerk, e.g., evaluation of clerk specifically with regard to various levels of training
4. Type of recommendations (projections) the evaluator is required to make, e.g., honors, counseling, research

Xenia Tonesk, Ph.D.
Director, AAMC Clinical
Evaluation Project
(202) 828-0561

aamc association of american medical colleges

STATEMENT OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ON

"THE SMALL BUSINESS INNOVATION DEVELOPMENT ACT"

(H.R. 4326)

The Association of American Medical Colleges (AAMC) is grateful to the Health and Environment Subcommittee for the opportunity to present its views on "The Small Business Innovation Development Act", H.R. 4326, particularly since the Small Business Committee was not able to accommodate a representative from the medical education community during national hearings on the bill last September.

The AAMC, as this Committee well knows, is over 100 years old and serves as a national voice for 126 accredited medical schools and their students; more than 400 of the major teaching hospitals in the United States; and over 70 academic and professional societies whose members are engaged in medical school teaching, patient care and biomedical research. Collectively, academic medical centers are the single largest producers of new scientific and technical

---

Submitted to the Committee on Energy and Commerce, Subcommittee on Health and the Environment for its hearing on H.R. 4326, "The Small Business Innovation Development Act", February 2, 1982.

knowledge in the health field through basic and applied research they conduct. This research is the well spring from which applied research flows, both in the academic medical center and the business world.

First, the Committee should be assured that the Association believes that fostering and exploiting the capability for "innovation" of small business is a laudable goal. This segment of the commercial and business community has contributed valuable products, growing out of basic discoveries made in research institutions, to the economy. However, the Association is profoundly convinced that the mechanism proposed to assist small businesses in their entrepreneural enterprise---set-asides derived from levies on the research and development budgets of the Federal science agencies---is bad public policy, an impediment to scientific progress and thus deleterious to the future health and well-being of the American people.

A careful reading of the legislative history of this proposal indicates that the set-asides are to be dedicated to funding two types of proposals submitted by small business firms: one, for research and development within the ambit of the mission of the funding agency; the other for the development of innovative products, goods and services based on recent scientific and technological advances. Each warrants examination.

Small Business Research

The Association is convinced that no special mechanism is necessary for the first of these, and that indeed the creation of

one would subvert and corrupt the traditional policy of awarding Federal research and development funds on the basis of the technical merit of the work proposed and the competence of the performer. Let me amplify.

"For-profits" are now eligible to submit unsolicited proposals to virtually all of the Federal agencies that support extramural R&D programs. The last significant barrier disappeared in January, 1982, when the Public Health Service (PHS), which includes the National Institutes of Health (NIH), opened its grant programs to "for-profits." The NIH had been strongly censured by representatives of the small business community for the "closed-door" policy that was recently abolished. The fact of the matter, however, is that even before that exclusion was imposed about two decades ago, few "for-profits" applied for research grants. The probable explanation is the previously prevailing patent policy.

Patent disincentives---in practical if not legal terms, the real bar to small business participation---disappeared with the enactment of P.L. 96-517. This statute radically modified Federal patent policy for academic institutions and small business. It allowed them to retain title to inventions resulting from Federally-funded research. Thereby participation in Federal R&D programs became far more attractive to business enterprises.

With the new patent law and the change in PHS grant eligibility in effect, the Association sees no need for a special

set-aside for small business research and development. These organizations should compete for available funds on the same basis as all other applicants and be judged on the scientific and technical merits of their proposals by the peer review processes that have functioned so well as quality control devices for Federal research programs. More importantly, this class of applicant should not, if unsuccessful in obtaining funds through the time honored competitive peer review process, be given a second chance for support by having access to a set-aside, dedicated solely to small business applicants. By the same token, funds should not be denied to more meritorious applicants from the non-profit sector in order to fund small businesses. The issue involved is not only one of fairness; it would be a public scandal to support lower quality research when higher quality applications already in hand are not being funded. A dual standard of quality, one for non-profits and a lower one for profit-making performers in indefensible public policy.

A set-aside for research by small business is thus both unnecessary and undesirable.

Small Business "Innovation"

Proponents of this bill tend to minimize the significance of the line of argument just cited since, in their view, the forte of small business is not research but a unique capacity for achieving the second goal of the bill, the introduction of

innovative products into the economy. The legislative history of H.R. 4326 indicates clearly an intent to assign a new role to Federal R&D agencies, or at least those that support R&D in the biological, behavioral and medical sciencies: the continuation of the research and development process to actual "tooling up" for the production of goods and services. In our free enterprise system, this latter function has traditionally been not only the responsibility but also the special and cherished opportunity, of the commercial entrepreneur, operating within the framework, methods, styles, and standards of the mercantile system. Why should this function suddenly become a public responsibility? What would be the consequences of such an expansion of government's role?

One might ask why research should not also be a private sector responsibility. Research has been heavily subsidized from public funds as a social good, for the obvious reasons that new scientific knowledge is not only the fountainhead of technological progress, but also has no viable source of support other than government. It is essentially axiomatic in economic analysis that private sector companies underinvest in research, since the investors cannot capture exclusive rights to the wealth that might accrue through exploitation of the results which they funded.

Presumably the rationale for now turning to the government for the support of bringing products to the market place is that without it, the nation's capacity for this vital activity will be seriously impaired. The Association is profoundly unpersuaded

In the field of medicine, there is no discernable lack of this activity. Commercial organizations, large and small, have favored us with a cornucopia of new products and services. Look only at the mind-boggling instrumentation ensemble in coronary intensive care units, at the complex array of equipment in modern departments of diagnostic or therapeutic radiology, at the extensive portfolio of laboratory measurements available from clinical pathologists or at the vast catalogues of powerful drugs and effective devices from which physicians can prescribe.

Entrepreneurs seem to have had little difficulty in funding their efforts through earnings, borrowings or equity capital for the simple reason that really good products and services for both health care delivery and biomedical research can be very profitably marketed. In the last 12-18 months, small business concerns proposing to exploit new discoveries on how DNA strands can be sliced and spliced, and on how clones of cells capable of producing single specific antibodies can be isolated and used to produce valuable biologicals, have been spectacularly successful in equity markets. Where is the evidence that private sector financing is unavailable?

Even if "market imperfections" in meeting capital needs could be convincingly demonstrated, why would it not be more appropriate for government subsidies to business to take the traditional forms: of tax incentives beyond those enacted in the last session of this Congress; of loan guarantees; of interest subsidies for private sector loans; or even of direct loans, at whatever interest rates might be required to accomplish the

objective. This well intentioned bill, ironically, could have the effect of subsidizing "losers", since the "winners", i.e., companies with really good ideas for marketable products, would use traditional private sector resources, rather than get involved with government and all that that entails; the government would be left "holding the bag" of proposals that private financiers had found unattractive.

The Association concludes that a set-aside for small business innovation is not only unnecessary, but also an unwarranted subsidy to profit-making companies.

The Price of Set-Asides

If the set-asides , as proposed in H.R. 4326 should become law, what harm, other than an unnecessary and less than optimal use of "modest" amounts of public funds, would result?

First of all, it is important to note that the amounts are not modest; the Congressional Budget Office estimates that a three percent tax on the R&D budgets of the cognate Federal agencies would amount to about $1.665 billion dollars in FY 1986. More importantly, it should be noted that: the average annual rate of growth over the last two years in appropriations for the NIH, the major Federal support agency for biomedical research, has been only 5%. Furthermore, growth in real dollars, i.e. in what goods and services the money can purchase, has declined by a little more than 4% per year over the last three years, because the rate of inflation has far outpaced increasing

appropriations. The scientific community is at this very moment anxiously awaiting the President's budget for FY 1983 to find out whether further reductions predicted by OMB last year will materialize. Thus, the proposed set-aside represents, both absolutely as well as relatively, a large additional decrement to already severe progressive retrenchments in research funds. These funds are diverted from the creation of new knowledge, the long-term well-spring of all innovation, to the short-term exploitation of the existing, finite and exhaustible storehouse of current knowledge to produce practical goods and services. Thus, it stimulates consumption of the "seed corn" on which future harvest depend.

The substantial diversion of support, from science and technology to practical art, is costly not only in terms of the science not done, and the scientific manpower not utilized, but also in the expensive demands it places on the operations of Federal agencies. To establish small business "innovation" programs, they will have to create parallel peer review systems for this new genre of activity since the existing ones, for the most part, are not suited, especially tempermentally, to deal with a different class of projects. The costs include not only those of funding the creation and operation of an external advisory apparatus, but also those incurred when Federal personnel, already in short supply in the R&D agencies, are transferred from understaffed programs and committed to the support of new ones.

Conclusion

The Association hopes that this summary of its position persuades you that its deep misgivings about H.R. 4326 are well founded and not frivolous or self serving. As stated, it perceives that the effects of the bill would be bad for public policy, lead to bad science, and represent a totally unnecessary expenditure.

The AAMC does not begrudge small business firms as much of the Federal R&D budget as they can win in open competition, be it one percent, three percent, or twenty percent. But they must win it, fair and square. The AAMC could support a program of small business subsidy for products based on science and technology: provided it were demonstrated to be necessary; provided the appropriate mechanisms---further tax incentives, loan guarantees, interest subsidies, direct loans---were adopted, and provided a dedicated new appropriation was made available, preferably through the Small Business Administration (SBA), accustomed to dealing with this community of entrepreneurs. The canard so frequently heard, that it is pusillanimous of the academic community to object to this so-called trivial one or three percent tax on Federal R&D buget cuts both ways; if the amount is that small, a separate new appropriation would not create any substantial additional strain on the Federal budget.

Recommendations

What course of action should be taken? The Association recognizes the jurisdictional problems created by the bill. The Small Business Committee has proposed statutory earmarks on programs in the arena of responsibility of a number of other Committees---Veterans' Affairs, Energy and Commerce, Armed Services, Science and Technology, Agriculture. The options available to this Committee are better understood by you than by the AAMC, but they at least include radically modifying the bill or recommending its outright disapproval, this Association's preferred outcome. Our major fallback recommendation, were our preferred outcome impossible, would be exemption, at the very least, of agencies supporting biomedical and behavioral research---the NIH, the Alcohol, Drug Abuse and Mental Health Administration and the Veterans' Administration---from the requirements of the bill.

The amendment to the Senate counterpart of H.R. 4326, introduced by Senator Schmitt, to protect national investments in basic research, would not be helpful in the biomedical and behavioral areas. The appropriations and budget requests of these agencies do not differentiate between amounts for basic research, for applied research and for development. Such determinations require difficult to impossible distinctions, except at the extremes. Further, a number of proposals that, in essence, tinker with the legislative language in the hope of taking some of the sting out of the bill as written would not

in the Association's view significantly improve a greviously flawed concept.

association of american medical colleges

Statement of the

Association of American Medical Colleges

on

The Economic and Social Ramifications of

Biomedical Research

The Association of American Medical Colleges (AAMC), the national voice for the nation's 126 operating medical schools, for over 400 teaching hospitals and for the faculties, staffs and students of these institutions is honored to have the opportunity to testify before this distinguished committee as you prepare to act on the Federal budget for FY 1983. The Association's message to you is straight-forward and simple.

- Scientific research in the biological and medical sciences is a spectacularly profitable investment in economic terms, social terms, and human terms.
- From the perspective of virtually any extant political ideology, biomedical research is an appropriate function for the Federal government to support and without that Federal support it will come to a crashing halt.

Presented to the House Budget Committee by Solomon H. Snyder, M.D., Professor of Neuroscience, Johns Hopkins University, February 25, 1982.

- Therefore, biomedical research should be given high priority and assured generous support, even in the stressed and distressing economic climate that currently prevails.

As you well know, during the quarter century between about 1940 to about 1965, the United States was able, principally as a result of unflagging Federal investments, to build a magnificent research and development enterprise in all of the physical, biological and medical sciences. Research, both basic and applied, found a congenial home in the academic sector, where generous Federal assistance encouraged the development of a thriving and dynamic program, conducted in well designed and splendidly equipped physical facilities. An important and unique dividend of academically-based research is the training of young scientists, since *the* method of graduate education is engagement, as an apprentice under guidance, in scientific research. In addition, the ambience created by vigorous research and graduate science education programs exerts a profoundly beneficent effect on the professional education processes in such a milieu. The overall impact is a remarkable enhancement in the quantity and especially the quality of the nation's human capital.

Developmental activities gravitated to industry but nonetheless received generous Federal support, especially in areas related to national security, space and energy. Domestic industry invested substantially in product improvement and innovation, with new small high technology firms

proliferating, thriving, merging and maturing.

The payoff for this Federal effort was impressive, whatever metric was employed to assess it.

- Since 1940, more than half of the Nobel prizes in science have been awarded to U.S. citizens.
- A relatively small group of universities, many of traditional excellance, seized upon the opportunity, committed themselves to the intense pursuit of new knowledge and became towers of national strength and distinction.
- Foreign students flooded our graduate schools.
- The U.S. became the acknowledged world capital in the natural sciences.
- The economy boomed, due in no small measure to research. Many studies, recently reviewed by the Joint Economic Committee in its report on Economic Change, indicate that investments in the research enterprise contribute significantly to the nation's economic growth and productivity, yielding an estimated average gross private rate of return of between 30 to 40 percent per year. Moreover, the social returns---uncompensated benefits to society as a whole---are believed to be about twice the private rate of return.
- Trade flourished, with the products of American industry capturing large shares of markets throughout the world.

- A national security apparatus of amazingly advanced technological capability was brought into existence and served the nation well when called to the test.
- After a short lag, our space efforts blossomed spectacularly before an astonished and awed world citizenry.
- In my own field, a revolution in knowledge and understanding took place and spilled over into medical practice with an enormous improvement in the ability of physicians to diagnose, treat and prevent disease. In this latter connection, I recently came across an excerpt from the debate on a bill, subsequently enacted as Public Law 71-251, to create the National Institutes of Health and provide it authority to train aspirant scientists. I was fascinated to read from a floor speech by Senator Joseph E. Ransdell the following:

> Disease is the greatest and most formidable enemy of human life...There are millions of sufferers from painful consuming diseases... about the nature, origin and cure of which little or nothing is known and which causes more deaths and economic waste than any other: as influenza, before which modern medicine remains impotent; measles, the offending organisms of which have not as yet been definitely proven; pneumonia, which baffle the skill of scientists; child bed sickness so fatal to mothers; infantile paralysis, which remains a curse to childhood; Brights disease, which is so prevalent

among adult men; mental troubles, heart lesions and venereal diseases, all of which take heavy toll of human life.

I do not have time in this brief statement to review for you the most recent major triumphs of biomedical research nor catalogue recent achievement in medicine. But I do wish to emphasize that in a period of just about 50 years, virtually every disease in the list mentioned by Senator Ransdell has come under control. While progress in science is slow and episodic, the perspective of half a century brings forcefully to our attention just how far we have come.

Despite the obvious return on research investments, the nation's commitment to scientific research began to flag in the mid to late 1960's; growth in Federal support first slowed, then leveled off and, most recently, began to decline. The causes for this change, as is the case for many social phenomena, is not unambiguously clear or a matter of consensus. But whatever the cause, the fact remains that our national, but especially our Federal, enchantment with research waned between 1965 and the present. Securing Federal support for research and development, except perhaps for national security purposes, has become an uphill fight, with consequences that are everywhere evident.

Academic institutions that had relied on Federal research funding to partially compensate tenured faculty have been faced with progressively more serious fiscal crises. Bright students, noting the steady decline in support for graduate education and the continued erosion of Federal

science investments, have legitimately concluded that alternative careers look more promising. Productive scientists have been unable to compete successfully for renewed support, despite the fact that their research grant applications earned priority scores that signified the high esteem in which their peers held their research contributions and proposals. The cumulative impact is a perceptible decline in the morale, vigor, and excellence of this country's scientific research enterprise.

Paradoxically, as the commitment of United States faltered, other nations, impressed by our achievements and using us as a model, began to invest heavily in scientific research and development. Even by 1960, Japan was putting a slightly larger percentage of its GNP into civilian R&D than was the United States and steadily increased the differential. By 1962, West Germany had also passed us in that type of investment and continued to increase the magnitude of the gap. The latest edition of Science Indicators published by the NSP graphically depicts the fading of the U.S. as the leading investor in science and in manpower for science. And virtually every page of the Wall Street Journal, Fortune Magazine, or the NY. Times Financial Section, describes the eclipse of the U.S. as the world's leading economic power. Japan has assumed world leadership in a number of technology-based industries---autos, cameras, hi-fi equipment; computers may soon be added to that list. West German technology-based industry is also flourishing.

The research capacity of many other developed nations is now in a growth phase while that of the U.S. is declining. Considering the long lag times to revitalize an industry, unless our course is reversed, catching up may be impossible. Moreover, our national tendency to seek "quick fixes" instead of long-term solutions only makes matters worse. For example, the response to the present acute shortage of engineers and computer scientists for the production needs of industry has been to allow engineering and computer science faculty to be seduced out of universities to meet the current urgencies, indifferent to the fact that no one is left to train the next generation of scientists in that field.

The pattern of support for biomedical science is generally similar to that of the other sciences: slow growth since 1965 to a peak in 1979, with a decline since. For example, the NIH appropriations, corrected for inflation, grew at an average compounded annual rate of 20% from 1950-1965. From 1965-1979, growth averaged 3.2% per year, overestimated somewhat by the impact of the war on cancer; omitting the NCI, the rest of the NIH experienced a growth rate of 2.6% until 1979. Since 1979, growth fell at a rate of about 5.0% per annum; the President's FY 1983 request, again adjusted for inflation, reflects a further 3% decline.

The AAMC strongly supports maintaining our national preeminence in biomedicine. In this sphere, the U.S. has not yet been eclipsed, an assertion that may not be true much longer. The importance of remaining strong is bolstered

by the almost unanimous forecasts that the 21st Century will usher in an "Age of Biotechnology" as the sequel to the current "Age of Information". Harbingers of this are already apparent in the early developments of recombinant DNA technology. Moreover, biomedical research promises not only a powerful new impetus for economic development, but, above all, enormous prospects for extending the length of human life and enhancing its quality. Without further research our citizens, their children and their children's children will receive no better medical care than that available to us today. We will not again witness the dramatic improvements that have occurred in your lifetimes and mine. But, with relatively modest additional Federal investments, the biomedical research enterprise that today is severely malnourished can be revitalized, energized and reach full flower.

Let me close on a technical note. The mainstay of the national effort---the appropriations to the NIH and the ADAMHA---are both minor components of the 550 functions of the budget, sandwiched between the grinding jaws of two huge entitlement programs of such size that biomedical and behavioral research could almost be lost in rounding-off figures for Medicare and Medicaid. A spartan ceiling on function 550, coupled with an inadvertantly low estimate for entitlement programs could amount to a coup de grace for research programs.

The Association does not hold with the conventional wisdom that argues all must suffer, more or less equally,

until the country's economic crisis is resolved. Rather, the resolution of this crisis and those of the next decade or two depend heavily on a vigorous and successful scientific research enterprise. This nation will spend over $250 billion dollars next year on health care. Yet the Federal government is investing only $4.0 billion or 1.6% in activities that hold the only real hope for significantly lowering this medical bill by the discovery of ways to cure and prevent disease. The less we spend this year on research, the more likely we will see an increased rate of health care cost escalation.

The Association recognizes the criticality of the current situation. It acknowledges the necessity of wide-spread belt tightening and sacrifice. But it is convinced that failure to expand research investments is counter-productive in the truest sense of that world.

Thank you for your attention.

aamc association of american medical colleges

Statement of
Case Western Reserve University School of Medicine
and the
Association of American Medical Colleges

on

Impact of the President's FY 1983 Budget Request

Chairman Simon, Members of the Committee, Ladies & Gentlemen:

I am Richard E. Behrman, Dean of the Case Western Reserve University School of Medicine. I am here today to represent not only the perspectives of my own institution, an independent privately supported school of medicine with an enrollment of 606 medical students, but those of the Association of American Medical Colleges which serves as the representative of our nation's 126 operating medical schools, their students and faculties. I appreciate the opportunity to share with you the views of my institution and the Association on the very serious impact the budget proposals being examined here today will have on the ability of the vast majority of students to finance a medical education. To obtain a realistic evaluation of these proposals, several questions must be considered:

- who is responsible for paying the cost of medical education;
- what are the possible effects of the Administration's proposal on the students; and
- do viable alternatives to the Guaranteed Student Loan (GSL) Program and National Direct Student Loan (NDSL) Program exist?

Presented by Richard E. Behrman, Dean, Case Western Reserve University School of Medicine before the Subcommittee on Postsecondary Education hearing on "Impact of the President's FY 1983 Budget Request on Higher Education," March 3, 1982.

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

PAYMENT OF EDUCATIONAL COST

In relation to the payment of medical education three points must be emphasized:

- First and foremost, the primary burden of financing a medical education should rest with the student and the student's family.
- Second, qualified students from all socioeconomic backgrounds should have the opportunity to enter and complete medical school including the average four-year postgraduate residency training.
- Finally, in order for students from lower and middle income families to accept the ultimate responsibility for their educational expenses, they will have to borrow money from Federal sources such as the Guaranteed Student Loan (GSL) and National Direct Student Loan (NDSL) Programs.

EFFECTS ON MEDICAL STUDENTS

We are seriously concerned over the Administration's proposal to terminate eligibility for graduate and professional students for the GSL Program and eliminate all new funding for the NDSL Program. In addition, it must be pointed out that the Administration has also recommended that funding in FY 1983 for the Health Professions Student Loan (HPSL) Program and the Exceptional Financial Need Scholarship (EFN) Program which were reduced 60 percent in FY 1982 be completely eliminated. If approved by Congress, these actions will devastate both the ability of students to borrow and the efforts of the medical schools to continue admitting students from low income and disadvantaged backgrounds.

The cost to the student for a medical education is quite significant. During the 1981-82 academic year the average total cost in the U.S. for first-year students including tuition, fees and all other expenses ranged from approximately $8,700 for state residents at public schools to over $15,900 at private schools. If students are to maintain responsiblity for financing their own education, they

must either meet these costs directly, or as 75 percent now do, borrow the funds and assume a debt burden which for the 75 percent of 1981 graduates with debt was just under $20,000.

In the 1980-81 academic year, medical students borrowed a total of $264.1 million dollars (table attached). Of that total, the GSL and NDSL Programs provided $205.3 million. These two programs accounted for 78 percent of all medical student loans from Federal and private sources. If loans from the HPSL Program are included, this figure increases to 86 percent of all loans.

The GSL is the major loan resource available to medical students. It provides 71 percent of all loan monies and accounts for nearly one-half of all financial assistance for medical students. Last year, approximately 72 percent of all the medical students in this country borrowed an average of about $4,500 to help pay for their education.

Borrowing patterns by Ohio's medical students reflect these national averages. During the 1980-81 academic year, over 2,700 Ohio students representing 76 percent of the medical schools' enrollment borrowed over $14 million from the Graduate Student Loan Program with an average loan totalling $5,100. At Case Western Reserve University School of Medicine 74 percent of our students are borrowing funds from the GSL Program. Four hundred forty-nine students have borrowed $2,241,000 this year for an average loan of $5,000 per student.

ALTERNATIVES

If the Administration is successful in eliminating the GSL, NDSL, and HPSL Programs as sources of loans for medical students there is simply no existing and viable alternative available. The Health Education Assistance Loan (HEAL) Program is inadequate due to lack

of active lenders and arbitrarily low lending ceilings imposed by the Administration. The program of Auxiliary Loans to Assist Students (ALAS), which the Administration has proposed as an alternative to the GSL Program, is unsatisfactory due to limited state participation, questionable lender interest, inadequate borrowing limits and the requirement of repayment of interest while students are still in school. Even if the suggestion to increase the maximum loan to $40,000 per student were accepted, the ALAS program will not serve as a feasible source of funds for these students.

Recently, the Ohio Student Loan Commission (OSLC) prepared an analysis of the ALAS program. The Commission discovered that if a student borrows the proposed maximum of $8,000 per year at 14 percent simple interest, he or she would be required to make interest payments of over $93 per month within 60 days of receiving the loan. Projected over 4 years of enrollment and borrowing at levels of $8,000 per year, monthly interest payments of $373 would have to be made during the last year of study. Thus, while still in school, some medical students would be required to borrow approximately $373 each month or almost $4,500 per year from other sources --- the existence of which are uncertain --- to pay this interest.

Students who borrowed the maximum amount of $40,000 for their medical education, following a two-year grace period, would face monthly payments of $621 in their third year of residency. These and other loan payments would come at a time when young physicians were initiating their careers after eight to twelve years of training. These payments would be added to other financial obligations including establishing medical practice, obtaining home mortgages and starting families. Such financial obligations would be likely to deter graduates from establishing careers in teaching,.research and primary-care

medicine, those careers which historically have provided lower incomes than technology based specialties and subspecialties.

It is not practical to consider states as potential sources of new alternative loan programs. Ohio, like many of the industrialized mid-western and eastern states, is experiencing its worst economic difficulties since the 1930's. At present, the state budget is facing a $1 billion deficit by June 30 of 1983 unless drastic improvements in the economy occur. There is little support for a new student loan program because there is no money available to capitalize one.

SUMMARY

In conclusion, the Administration's FY 83 budget proposals would almost completely halt student funding for medical education. Since no viable alternatives to GSL and NDSL would be available, low and middle income and underrepresented minority students would be virtually precluded from pursuing medical careers. A significant number of students would be forced to terminate their studies, some temporarily, others permanently.

- The nearly three-fourths of all medical students willing to assume the financial responsibility for their education through borrowing would be prohibited from doing so.
- The characteristics of medical students and the practicing physicians of the future would be altered by causing a shift from those who are the most academically qualified to those who are the most economically able to pay the cost of medical education.
- Many medical students would be compelled to enter higher paying specialties, normally located in large urban areas, so that they can afford to pay the interest and principal on their educational loans.

- Thus, Federal and state initiatives to increase the number of primary care physicians in less lucrative, underserved rural and inner-city areas could be seriously impaired.

We understand the desire to reduce expenditures for the GSL Program; however, it is highly inequitable to place such a disproportionate burden of this retrenchment so heavily upon one segment of the higher education community, namely, graduate and professional students. A better strategy would be to focus a savings effort on those individuals who do not make best use of the program. For example, the program could be limited only to degree students who are making satisfactory progress. A mechanism for income verification could ensure that all GSL loans are based on accurate income information. In addition, the special allowance payment to the lender might be gradually transferred to the student beginning several years into repayment. These methods, unlike the Administration's proposal, would achieve savings without a disruption in the supply of properly educated individuals in medicine, law, business, engineering, theology, the arts and politics; in sum, those areas upon which our future national welfare will depend.

Students from low and middle income families need your help <u>now</u>. The future physicians, scientists and medical educators in this country need your help now. All 126 medical schools in this nation have joined together with the Association of American Medical Colleges to seek your help in opposing the Administration's proposals and in preventing further reductions in student financial aid programs. As one observer recently remarked, "If the cost of education seems high, ponder the cost of ignorance."

ATTACHMENT

MEDICAL STUDENT SOURCES OF LOAN FUNDS

1980 - 1981

Programs to be Eliminated from FY '83 Budget	$ in millions	Percent
Guaranteed Student Loans	189.3	71
National Direct Student Loans *	16.0	6
Health Professions Student Loans*	22.7	9
Subtotal	228.0	86
Remaining Sources		
Health Education Assistance Loans	15.3	6
All Other	20.8	8
Subtotal	36.1	14
Grand Total	264.1	100

*Includes Revolving Funds

aamc association of american medical colleges

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

202: 828-0460

February 12, 1982

Honorable Doug Walgren
Chairman
Subcommittee on Science,
Research and Technology
Committee on Science and Technology
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

As you know, the constituency of the Association of American Medical Colleges (AAMC) comprises the largest single component of the Nation's biomedical and behavioral research enterprise. As such, its membership is deeply concerned with any legislation that would impact its ability to continue scientific investigation in these arenas. Thus, the AAMC appreciates this opportunity to submit its comments on the draft animal research proposal which your staff recently circulated.

Outlined below are the Association's specific comments on the draft proposal:

Statement of Findings

Section 2 prefaces the draft bill with a series of Congressional findings on the use of animals for research purposes. The Association believes that two of these statements, in particular, warrant revision:

- Section 2(1) asserts that "non-animal methods of testing are being developed which shows promise of being faster, cheaper, and more accurate than traditional animal experiments; and further opportunities exist for the rapid development of these methods of testing." The AAMC suggests that the wording of this finding--the promise inherent in alternative methods--requires clarification to ensure that its applicability is realistic, such as to testing procedures substituting for the Draize test utilized for cosmetic products.

If meant to encompass research methods in general, the statement very seriously inflates the state of the art.

- Section 2(4) states that the scientific community needs to appreciate the depth of public concern for protection of all life and to improve self-regulating measures that respect this concern. The Association recommends deletion of this language. In addition to the fact that it is gratuitously and unduly pejorative, there is no proof that a body of evidence exists to support this claim.

Title I: Development of Improved Testing Methods

Non-Animal Testing Methods

Section 101 would: authorize the Secretary of the Department of Health and Human Services (HHS) to make grant and contract awards to sponsor the development of non-animal methods of research, experimentation and testing; provide authorizations for funding for these purposes; and establish a unique peer review group to review these applications.

These provisions raise a number of concerns which the AAMC believes deserve serious consideration:

- The concept of establishing a specific program targeted exclusively on these objectives is of highly dubious merit as it is based upon a misconception of the way the scientific process operates. Most significant advances in research methodology occur in the course of scientific investigation having an identified substantive objective. The domain in which the development of new techniques would seem at least possible and would certainly be desirable, namely, testing, should be identified more precisely. Moreover, given recent and generous private sector support for R&D in this area, the need for Federal support should be more closely scrutinized and convincingly justified.

- The establishment of the "special *ad hoc* study section" with statutorily mandated membership requirements is an unwise and unprecedented departure from long-standing public policy, and is one to which the AAMC wishes to voice its strongest opposition. Current practice leaves the composition of initial review groups to the discretion of the NIH Director, under authority delegated by the Secretary of the Department of HHS. There does not

appear to be justification for not continuing what has proven to be an exemplary system for garnering the necessary expertise to perform functions of scientific review and providing an important degree of managerial flexibility to accommodate the unpredictable nature of scientific progress. If the intent in circumventing existing mechanisms to review research protocols of this type is to ensure that approved projects are actually funded, it is based on a failure to understand that funding is the responsibility of the National Advisory Council and the Institute Director, not the Initial Review Group.

- There are the obvious budgetary concerns. Given the current constraints on government spending, the appropriations of new funds for this purpose is unlikely. Funds for an "alternative methods" program will surely be derived from a reduction in support for on-going programs of the National Institutes of Health, an agency that is already facing serious retrenchments. This proposal also appears to ignore the fact that the NIH already expends significant sums on research which does not involve the use of animals.

Additional Responsibilities of the Secretary

Section 102 would require the Secretary, in consultation with the Food and Drug Administration, the Environmental Protection Agency, and the National Toxicology Program and other appropriate agencies, to promote: the design of new programs using non-animal testing methods which will satisfy public health and safety concerns as well as current regulatory requirements; and the use of non-animal methods by seeking cooperation in international research and development programs by enhancing existing data storage and retrieval systems.

On balance, the Association believes that such functions appear to be both reasonable and desirable.

Title II: Federal Research Grant Requirements

Certification Requirements

Section 202 mandates that, within three years of enactment of this legislation, a research entity must obtain certification that it is qualified to engage in research involving animals by a recognized certifying agency approved and designated by the

Secretary; these designations will be reviewed at least once every five years by the Secretary. Such designations will be contingent upon the determination that the agency or agencies, among other qualifications: possess the demonstrated capability to ascertain the qualifications, background and experience of research entities "in the use of animals for such purposes."

Moreover, this section provides that the Secretary be granted authority to waive these certification requirements "under exceptional circumstances related to the needs for research results or special and unusual circumstances of the research entity".

These provisions raise a number of concerns, the most pressing being the financial ability of many research entities to obtain AAALAC certification within the brief time frame proposed by the legislation. It must be recognized, that, while most facilities meet adequate and desirable standards, AAALAC standards represent the ideal; the majority of entities receiving NIH support are not AAALAC certified. Thus, compliance with this section would place many entities under severe financial stress or even force them to discontinue research.

Also of concern are those provisions that would:

- Specify the requirement that the certifying body possess the ability to "ascertain the qualifications, background and experience of research entities in the use of animals..." AAALAC, which would presumably be formally designated by HHS to be the certifying agency, currently addresses only the care of animals and facility specifications. This provision would add yet another function requiring AAALAC review. This clearly raises the question of both AAALAC's ability to make such a determination and the appropriateness of granting it such a responsibility.

- Permit the Secretary to waive certification requirements under certain circumstances. The wisdom of this provision merits further scrutiny. At first blush, it appears that such authority would provide the needed flexibility to deal with many of these requirements. Upon closer examination, it would probably prove to be a very weak reed to rely upon: the justification process for a waiver would undoubtedly evolve into a justification for the use of animals for experimental purposes.

Assurance Requirements

Section 203 would essentially cast in statute many of the details and policies set forth in the NIH's "Policy on Humane Care and Use of Animals," including the establishment of an Institutional Animal Care Committee. Of concern to the Association are several of the provisions which would extend, unreasonably in the AAMC's opinion, beyond the NIH Guidelines. Specifically:

- Sections 203(2)(B) would essentially grant veto power over inspection reports and the review of protocols to the veterinarian and the non-affiliated members. The Association is of the view that empowering any member(s) with veto power is of questionable wisdom in that it vests enormous authority, without adequate justification, in those members and infers that other committee members would not act responsibly. It should be noted a similar requirement is not embodied even in the regulations designed to protect human research subjects. This provision has been interpreted as intending only to ensure the physical presence of these members. Such an interpretation does not ameliorate the Association's objection to such an unjustified and pejorative requirement.

- Section 203(5) would require that as a condition for service, each committee member would be responsible for providing the Animal and Plant Health Inspection Service of the Department of Agriculture, the granting Federal agency and the certifying agency of "any animal care conditions which require immediate attention or which have been persistently neglected". Such a requirement could prove highly divisive and disruptive, could well discourage individuals from assuming the burdens such committee work entails, and ignores well-established and important channels of communication within institutions.

- Section 203(3)(A) mandates that the animal care committee review research protocols "for appropriate treatment, care, and experimental design..." The Association takes strong exception to the latter function; the composition of the committee does not suggest nor require that the individual members possess the expertise necessary to make sophisticated and detailed scientific evaluations of a wide range of research protocols. This function is already discharged by those qualified to do so -- the initial review groups in the sponsoring Federal agencies.

Coordination

Embodied in Section 204 are requirements related to further coordination in ensuring compliance with the inspection and certification specifications proposed by the bill. While the Association views efforts to ensure coordination as laudable, it finds the means outlined in the proposal confusing. It is very unclear as to which entity would have the predominant role in this area--the Department of Health and Human Services or the Department of Agriculture.

Definitions

Section 205(3) defines the term "animal" as "a warm blooded animal". In our view, this definition is unnecessarily and unwisely broad as it would include human beings and exclude some species used in experimental work. The AAMC sees no reason why the current definition of the term animal in the Animal Welfare Act would not suffice.

Title III. Special Procedures

Federal Agency Review of Grant Proposals

Section 301 would essentially prohibit Federal agencies from funding any research or testing proposals involving animals unless certain requirements were met. Overall, the Association believes that these are in large measure unnecessary and would be, in many instances, virtually impossible to implement. Specifically:

- In any case involving the use of large numbers of animals, assurances would be required that a consulting veterinarian had been employed in planning these procedures and would be employed in their implementation. While the former requirement might add a marginal increment of protection in some cases, the fulfillment of such a requirement in the actual conduct of research would be impossible--there are not now, and never will be, enough veterinarians in existence to satisfy this mandate.

- In any case involving surgery or other invasive procedures, appropriate assurances of the proper use of analgesics and anesthetics and a separate identification of the funds that will be spent for these items would be required. Such a mandate is a non-productive bookkeeping exercise. The amount of money spent bears no relationship to the quality or quantity of the analgesics, anesthetics or the procedures employed.

- A justification for "anticipated animal suffering in terms of demonstrable benefits of the research" would

be required. This requirement would be virtually impossible to operationalize; such a specification does not exist even for research involving humans, where an approximate measure of the phenomenon is possible.

Again, the AAMC is deeply appreciative of this opportunity to review and comment on such important legislation. Furthermore, the Association strongly applauds your efforts to seek the input of all concerned parties prior to the introduction of formal legislation.

If I or members of my staff can supply you with additional information, please don't hesitate to contact me.

Sincerely,

Thomas J. Kennedy for HD

John F. Sherman, Ph.D.
Vice President

cc: Members of the Subcommittee
on Science, Research and Technology

aamc association of american medical colleges

March 2, 1982

The Honorable Richard S. Schweiker
Secretary
Department of Health and Human Services
Washington, D.C. 20201

Dear Mr. Secretary:

On behalf of the Executive Committee of the Association of American Medical Colleges, I am writing to express the deep dismay which has been raised by the proposal in the FY1983 budget to limit reimbursement of indirect costs on research grants awarded by the National Institutes of Health.

It is the considered opinion of the Association that this proposal has several serious defects:

- It constitutes an arbitrary and unjustified refusal on the part of the government to pay adequately for one component of federally supported research projects--indirect costs--almost as if these were not as real as direct costs even though they are accounted by a different but equally appropriate method. The infrastructure so necessary to the nation's biomedical research enterprise cannot be maintained adequately in the face of the proposed reduction.

- It will almost certainly seriously damage the enterprise, one of the few areas in which our nation retains world pre-eminence. Its effect will be to force a reduction in the amount of research undertaken by the institutions that conduct the greatest portion of that research or to increase the share of their own funds that they must add to projects that make up the research agenda. The latter possibility seems increasingly unlikely because it would coincide with significant reductions in funding from a variety of other sources for a wide spectrum of academic programs. To be more specific, the intensity of research activity actually undertaken can fluctuate in direct proportion to the amount of direct costs provided in an award. However, the same relationship does not obtain with respect to indirect costs. If the reimbursement for these costs is reduced by any percentage, there is no incentive to strive to reduce them because the same percentage reduction will apply at whatever level of reimbursement.

- It is inequitable in its impact for two reasons:

  - Accounting conventions vary among schools such that the same item of cost may be reported as "direct" by some institutions

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

and "indirect" by others. The proposal provides a powerful incentive to revise accounting practices to show more costs as direct--an expensive and fundamentally unproductive drain on institutional resources to maximize reimbursement for total costs.

- It disproportionately penalizes institutions which have conscientiously constrained and minimized indirect costs.

We join the signatories of the letter from the Joint Committee on Health Policy of the AAU/ACE/NASULGC in urging that you reject this approach to the solution of the NIH funding problem. The Association takes this position in the full realization that unless more money is appropriated for these research programs, the consequence would be a reduction in the number of competing research grants awarded by NIH. Given the documented potential of biomedical research as a truly cost effective way to reduce health care costs in the long run, such a reduction in the number of awards for competing applications would also be shortsighted.

Sincerely yours,

Thomas K. Oliver, Jr., M.D.
Chairman

cc: Edward N. Brandt, Jr., M.D.
Thomas E. Malone, Ph.D.
Executive Committee

aamc association of american medical colleges

March 9, 1982

Honorable Robert J. Dole
Chairman
Finance Committee
United States Senate
2213 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

According to its Fiscal Year 1983 budget request, the Administration intends to soon put before you a legislative proposal designed to restrict significantly the use of federal tax-exempt revenue bond financing. Some of the provisions under consideration would virtually terminate the availability of such financing to non-federal, not-for-profit hospitals. For these public purpose institutions, tax-exempt financing now is the source of well over half of their construction capital. On behalf of the membership of the Association of American Medical Colleges (AAMC), I wish to express several concerns regarding this Administration proposal and request that pursuit of this course of action be rejected by you and your Congressional committee colleagues.

The Association's constituency includes all of the nation's medical schools, 74 academic societies, and more than 325 non-federal, not-for-profit hospitals. These hospitals participate in the Medicare program; account for sixteen percent of the admissions and twenty percent of the ambulatory services provided by non-federal short-term hospitals; provide a comprehensive range of patient services, including the most complex and intensive tertiary care services; and are responsible for a majority of the nation's medical education programs. Moreover, these hospitals account for 35.4 percent of the patient bad debt deductions and nearly half of the charity care deductions at all short-term community hospitals in the United States. Thus, a proposal that would limit the federal tax exemption for interest on private, nonprofit hospital bonds is of direct and vital interest to the AAMC, its members, and the communities and publics they serve.

NO EVIDENCE LINKING TAX-EXEMPT FINANCING TO HOSPITAL OVERBEDDING

Previous efforts to restrict the availability of tax-exempt hospital bonds have been based on the assumption that a causal relationship exists between the use of such financing and the construction of unneeded hospital beds. Treasury Secretary Regan's discussion of the misuse of industrial revenue bonds to build "unneeded hospitals and hamburger stands," which appeared in the January 12, 1982 New York Times, leads one to believe that the current Administration believes similarly.

The AAMC contends that there is no evidence which supports this assumption. In fact, according to the Bureau of Census' own figures, annual completed hospital construction dropped 35 percent between 1971 and 1979 when measured in constant (1967) dollars. Inversely, for the same time period, the

Congressional Budget Office (CBO) reports that the volume of hospital tax-exempt bonds issued rose 672 percent. Thus, despite the rapid increase in hospital tax-exempt bond use, hospital construction in real dollars declined, strongly contradicting the assumption of a positive correlation between the two.

In addition, the vast majority of hospital construction projects are undertaken specifically to replace or renovate antiquated, inefficient and substandard facilities and equipment, or to convert existing facilities in response to evolving medical practice and patient demand patterns (e.g., transforming inpatient facilities into ambulatory care units). These are necessary and legitimate projects which require capital, but add no new beds to the existing health care delivery system. According to the American Hospital Association's Hospital Construction Survey, only 28.4 percent of hospital capital projects undertaken in 1978 were for new construction. Clearly, the premise that tax-exempt hospital financing invariably results in more beds is erroneous.

EFFECTIVE GOVERNMENTAL AND MARKETPLACE MECHANISMS TO MONITOR THE NEED FOR HOSPITAL CAPITAL EXPENDITURES EXIST

As it argued in its comments on a restrictive proposal made by OMB under the previous Administration, the Association believes that any arbitrary legislative plan to limit tax-exempt financing for hospital capital projects would lead to an inappropriate role for the federal government in the capital marketplace. It would also ignore existing federal health planning authority, and many state regulatory agencies, responsible for monitoring need for major capital expenditures by hospitals.

Under the various Certificate Of Need (CON) review provisions of the National Health Planning Act (P.L. 93-641) and its amendments (P.L. 96-79), Health Systems Agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) are required to certify the need for capital expenditures, major medical equipment acquisitions, and new institutional health services proposed by hospitals. These decisions must be based on such criteria as the appropriateness of the costs and methods of proposed construction, the application of national guidelines which include a standard for overbeddedness, and the impact on patient care costs and charges at the proposing institution and other area facilities.

Tax-exempt bonds are purchased by private investors in competition with other investment opportunities and are therefore subject to the self-regulating investment market. To limit their risk and assess a hospital's debt repayment potential, investors have historically conditioned their purchase of tax-exempt bonds on CON approval of projects. The certificates are viewed as expressions of community need, economic soundness and the will of the people. These principles have also been of primary importance to state bond issuing authorities in their determinations to approve or deny tax-exempt financing for hospital projects.

In the absence of evidence to support the assumption of a linkage between the availability of federal tax-exempt hospital financing and construction of excess hospital beds, the Association recommends that the federal government maintain its current policy on tax-exempt hospital bonds. It must not attempt to displace the combination of local level decision-making and consumer choice with some form of arbitrary federal statutory proscription and new burdensome regulation.

THE TREASURY'S ESTIMATED REVENUE LOSS DUE TO TAX-EXEMPT HOSPITAL BOND ISSUANCES IS OVERSTATED

The Association respects the Administration's efforts to identify new revenue sources to offset the burgeoning federal budget deficit. However, it must take issue with CBO's current projections of $100 million, $200 million, and $300 million in Treasury revenue losses due to new tax-exempt hospital issues for Fiscal Years 1982, 1983 and 1984 respectively. These estimates are believed to be overstated because:

- o they fail to account for the reduced federal Medicare and Medicaid reimbursement outlays attributable to the lower interest expenses of tax-exempt financed hospitals;
- o they fail to account for increased personal and corporate tax revenues paid by hospital employers and contractors; and
- o tax rate reductions enacted in the Economic Recovery Act of 1981 will reduce the cost of tax exemptions to the government and the loss of Treasury revenue in turn.

Thus, the AAMC strongly opposes the limitation of federal tax-exempt hospital financing as an overestimated response to the dubious premise that such financing contributes significantly to excess hospital bed capacity and federal government expense.

TAX-EXEMPT FINANCING FOR NON-FEDERAL NOT-FOR-PROFIT HOSPITALS IS BOTH APPROPRIATE AND NECESSARY IN THE PUBLIC INTEREST

Non-federal not-for-profit hospitals are an essential component of our nation's health care system, serving an undeniable public purpose. The vast majority of teaching hospitals in the U.S. belong to this hospital group and provide vital and highly complex patient services, often at no charge to the poor and medically indigent. Additionally, these institutions serve society through their education and research missions which advance biomedical science and technology and supply the nation's health manpower. The proper maintenance and continuing viability of these institutions depends upon their success at capital formation.

Eliminating or restricting significantly the tax-exempt status of hospital bonds would prevent financially weaker institutions from undertaking necessary improvements and would raise considerably the cost of borrowing capital to more financially stable hospitals (and thereby also increase the federal and state level reimbursement claims of these institutions). The federal government's reimbursement policies under the Medicare and Medicaid have had a prohibitive effect on not-for-profit hospitals as well. These policies tend to cover less than the full costs of operation for these hospitals and deny them a return on equity accorded proprietary institutions. Moreover, recent legislative amendments have further reduced federal reimbursement. This has taken its toll disproportionately on the revenue of not-for-profit institutions, and teaching hospitals particularly, because they serve proportionately more Medicare and Medicaid patients.

As a result, the not-for-profit hospitals are rapidly consuming all their own available capital raised through earnings accumulation and charitable contributions and are assuming more and more debt to acquire financing.

Because they do not pay income tax and receive no benefits from tax incentives (e.g., investment tax credits or deduction of interest expense), not-for-profit institutions view the tax-exempt financing mechanism as a means of making their borrowing costs comparable to those of proprietary hospitals. Should this mechanism be terminated or curtailed seriously, many of the financially weaker, though essential, hospitals would be forced to join the sizable group of urban and rural hospitals that are operating on the fringe of insolvency.

Furthermore, it must be recognized that the nation's health care delivery system is an integrated and interdependent one. Impairing the ability of not-for-profit institutions to adequately meet community needs and maintain public health will adversely affect, and in many instances irreversibly strain, the capabilities of other public and private hospitals in the country that would have to assume greater responsibility as demand for health services is shifted to them. An erosion of the quality of care in the system inevitably would follow.

CONCLUSION

In summary, the AAMC strongly urges the federal government to maintain its present policy regarding hospital use of federal tax-exempt bonds and discontinue activity to adopt a legislative proposal that would limit such bond use. This recommendation is based on the following grounds:

(1) There is no evidence linking tax-exempt financing to hospital overbedding.

(2) Governmental and marketplace controls exist to monitor the need for hospital capital expenditures and need not be displaced or duplicated.

(3) The Treasury's estimated revenue loss due to tax-exempt hospital bond issuances is overstated.

(4) Tax-exempt financing for non-federal, not-for-profit hospitals is both appropriate and necessary in the public interest.

I appreciate this opportunity to express the Association's concerns and suggestions on the issue of federal tax-exempt hospital financing and hope they will be considered seriously in your deliberations in the days ahead. I, and members of the AAMC staff, would be pleased to discuss these matters further with you at any time.

Sincerely,

John A.D. Cooper, M.D.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - March 1982

ALABAMA		
University of Alabama	*James A. Pittman , Jr.*	
University of South Alabama	*Stanley E. Crawford*	
ARIZONA		
University of Arizona	*Louis J. Kettel*	
ARKANSAS		
University of Arkansas	*Thomas A. Bruce*	
CALIFORNIA		
University of California - Davis	*Hibbard E. Williams*	
University of California - Irvine	*Stanley van den Noort*	
University of California - L.A.	*Sherman M. Mellinkoff*	
University of California - San Diego	*Robert G. Petersdorf*	
University of California - San Fran.	*Julius R. Krevans*	
Loma Linda University	*G. Gordon Hadley*	

COD Roll Call - March 1982

University of Southern California	*Allen W. Mathies, Jr.*	
Stanford University	*Dominick P. Purpura*	
COLORADO		
University of Colorado	*M. Roy Schwarz*	
CONNECTICUT		
University of Connecticut	*Robert U. Massey*	
Yale University	*Robert W. Berliner*	
DISTRICT OF COLUMBIA		
Georgetown University	*John B. Henry*	
George Washington University	*L. Thompson Bowles*	
Howard University	*Russell Miller*	
FLORIDA		
University of Florida	*William B. Deal*	
University of Miami	*Bernard J. Fogel*	

COD Roll Call - March 1982

University of South Florida	*Andor Szentivanyi*	
GEORGIA		
Emory University	*James F. Glenn*	
Medical College of Georgia	*Fairfield Goodale*	
Morehouse	*Louis W. Sullivan*	
HAWAII		
University of Hawaii	*Terence A. Rogers*	
ILLINOIS		
Chicago Medical School	*Marshall A. Falk*	
Loyola University	*Clarence N. Peiss*	
Northwestern University	*James E. Eckenhoff*	
Rush Medical College	*Henry P. Russe*	
Southern Illinois University	*Richard H. Moy*	
University of Chicago	*Robert B. Uretz*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - March 1982

University of Illinois	*Marten M. Kernis*	
INDIANA		
Indiana University	*Steven C. Beering*	
IOWA		
University of Iowa	*John W. Eckstein*	
KANSAS		
University of Kansas	*Marvin I. Dunn*	
KENTUCKY		
University of Kentucky	*D. Kay Clawson*	
University of Louisville	*Donald R. Kmetz*	
LOUISIANA		
Louisiana State - New Orleans	*Paul F. Larson*	
Louisiana State - Shreveport	*Perry G. Rigby*	
Tulane University	*James T. Hamlin III*	

COD Roll Call - March 1982

MARYLAND		
Johns Hopkins University	*Richard S. Ross*	
Uniformed Services University of the Health Sciences	*Jay P. Sanford*	
University of Maryland	*John M. Dennis*	
MASSACHUSETTS		
Boston University	*John I. Sandson*	
Harvard Medical School	*Daniel C. Tosteson*	
University of Massachusetts	*Robert E. Tranquada*	
Tufts University	*Robert I. Levy*	
MICHIGAN		
Michigan State University	*W. Donald Weston*	
University of Michigan	*John A. Gronvall*	
Wayne State University	*Henry L. Nadler*	

MINNESOTA		
Mayo Medical School	*John T. Shepherd*	
University of Minnesota - Minneapolis	*Neal L. Gault, Jr.*	
University of Minnesota - Duluth	*Paul Royce*	
MISSISSIPPI		
University of Mississippi	*Norman C. Nelson*	
MISSOURI		
University of Missouri - Columbia	*Charles C. Lobeck*	
University of Missouri - Kansas City	*Harry S. Jonas*	
Saint Louis University	*David R. Challoner*	
Washington University	*M. Kenton King*	
NEBRASKA		
Creighton University	*James E. Hoff*	
University of Nebraska	*Alastair M. Connell*	

COD Roll Call - March 1982

NEVADA		
University of Nevada	*Robert M. Daugherty, Jr.*	
NEW HAMPSHIRE		
Dartmouth Medical School	*Robert W. McCollum*	
NEW JERSEY		
CMDNJ - New Jersey Medical School	*Vincent Lanzoni*	
CMDNJ - Rutgers Medical School	*Richard C. Reynolds*	
NEW MEXICO		
University of New Mexico	*Leonard M. Napolitano*	
NEW YORK		
Albany Medical College	*Robert L. Friedlander*	
Albert Einstein Medical College	*Ephraim Friedman*	
Columbia University	*Donald F. Tapley*	
Cornell University	*Thomas H. Meikle, Jr.*	

Mount Sinai School of Medicine	Thomas C. Chalmers	
New York Medical College	Samuel H. Rubin	
New York University	Ivan L. Bennett, Jr.	
University of Rochester	Frank E. Young	
SUNY - Buffalo	John P. Naughton	
SUNY - Downstate - Brooklyn	Stanley L. Lee	
SUNY - Stony Brook	Marvin Kuschner	
SUNY - Upstate - Syracuse	George F. Reed	
NORTH CAROLINA		
Bowman Gray School of Medicine	Richard Janeway	
Duke University	Ewald W. Busse	
East Carolina University	William E. Laupus	
University of North Carolina	Stuart Bondurant	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - March 1982

NORTH DAKOTA		
University of North Dakota	*Tom M. Johnson*	
OHIO		
Case Western Reserve University	*Richard E. Behrman*	
University of Cincinnati	*Robert S. Daniels*	
Medical College of Ohio - Toledo	*John P. Kemph*	
Northeastern Ohio Universities	*Robert A. Liebelt*	
Ohio State University	*Manuel Tzagournis*	
Wright State University	*William D. Sawyer*	
OKLAHOMA		
University of Oklahoma	*Charles B. McCall*	
Oral Roberts University	*Sydney A. Garrett*	
OREGON		
University of Oregon	*Ransom J. Arthur*	

COD Roll Call - March 1982

PENNSYLVANIA		
Hahnemann Medical College	*Joseph R. DiPalma*	
Jefferson Medical College	*Frank Gray, Jr.*	
Medical College of Pennsylvania	*Alton I. Sutnick*	
Pennsylvania State University	*Harry Prystowsky*	
University of Pennsylvania	*Edward J. Stemmler*	
University of Pittsburgh	*Don Leon*	
Temple University	*Leo M. Henikoff*	
RHODE ISLAND		
Brown University	*David S. Greer*	
SOUTH CAROLINA		
Medical University of South Carolina	*W. Marcus Newberry, Jr.*	
University of South Carolina	*Roderick J. Macdonald, Jr.*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - March 1982

SOUTH DAKOTA		
University of South Dakota	Charles Hollerman	
TENNESSEE		
East Tennessee State University	Herschel L. Douglas	
Meharry Medical College	Charles W. Johnson	
University of Tennessee	Robert L. Summitt	
Vanderbilt University	John E. Chapman	
TEXAS		
Baylor College of Medicine	William T. Butler	
University of Texas - Dallas	C. Kern Wildenthal	
University of Texas - Houston	Ernst Knobil	
University of Texas - San Antonio	Marvin R. Dunn	
University of Texas - Galveston	George T. Bryan	
Texas Tech University	J. Ted Hartman	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - March 1982

Texas A & M University	*Robert S. Stone*	
UTAH		
University of Utah	*G. Richard Lee*	
VERMONT		
University of Vermont	*William H. Luginbuhl*	
VIRGINIA		
Eastern Virginia Medical School	*Ashton B. Morrison*	
Medical College of Virginia	*Jesse Steinfeld*	
University of Virginia	*Norman J. Knorr*	
WASHINGTON		
University of Washington	*John D. Chase*	
WEST VIRGINIA		
Marshall University	*Robert W. Coon*	
West Virginia University	*John E. Jones*	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COD Roll Call - March 1982

WISCONSIN		
Medical College of Wisconsin	*Edward J. Lennon*	
University of Wisconsin	*Arnold L. Brown, Jr.*	
PUERTO RICO		
University of Puerto Rico	*Pedro J. Santiago Borrero*	
Ponce	*José N. Correa*	
LEBANON		
American University of Beirut	*Raja Khuri*	