

*attend heads
Clark
Murray
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Kenney*

*Dr. [unclear]
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AGENDA

EXECUTIVE COMMITTEE
of the
COUNCIL OF ACADEMIC SOCIETIES

*Ellis [unclear]
[unclear] etc.*

Tuesday, June 24, 1969

Georgetown West Ballroom
Washington Hilton Hotel
Washington, D.C.

*Printing +
alternates*

- I. Minutes of meeting - March 23, 1969
- II. Proposed program for 1969 annual meeting
- III. Agenda for 1969 annual business meeting
- IV. Status of National Library of Medicine project
- V. Nominations for staff position
- VI. Status of CAS Workshop
- VII. Position paper - Corporate Responsibility for Graduate Medical Education
- VIII. Proposal - Commission on Medical Education
- IX. Reconsideration of Bylaws of the CAS
- X. Membership applications of new societies

ITEM I

MINUTES

EXECUTIVE COMMITTEE
COUNCIL OF ACADEMIC SOCIETIES

March 23, 1969

Washington, D.C.

Present: Drs. Jonathan Rhoads, Dan Tosteson, Thomas Kinney, Sam Clark,
Harry Feldman
Absent: Drs. Ralph Wedgwood, James Warren, John Nurnberger
Staff: Drs. John Cooper and Cheves Smythe

Dr. Rhoads read the minutes of the previous meeting; Dr. Tosteson moved their approval.

Dr. Cooper reviewed briefly the events of the past few months and stressed his attempts to reach a deeper understanding of the programs of the Association, to get to know the various people involved better, to arrive at more effective comprehension of the budgetary and financial position of the Association, and to accomplish the move of the Association from Evanston to Washington.

Dr. Kinney analyzed the recent National Library of Medicine meeting and summarized his perceptions of it. There was general agreement with his concept of this meeting. Dr. Smythe summarized his presentation to the Board of Regents of the Library to be made on March 24, 1969. This will include a report of the conference and the Association's follow-up. This led to a detailed discussion and analysis of the conference and its dominant theme. The conclusions were that the presentation to the Board of Regents should stress, (a) support for the biomedical communications network, especially as a teaching aid and not as a collection of superior hardware; (b) emphasis on the formation of a strong resource center; (c) recognition of the strength and power of goal directed learning with descriptions of floors of knowledge and qualifying examinations, but, at the same time, recognizing that such developments might not be considered to be proper functions of the National Library of Medicine; (d) support for further exploration of the application of computer-stored materials to clinical teaching and problems; (e) little emphasis on the precise organizational mechanisms through which the BCN might discharge its mission; (f) heavy emphasis on the willingness and determination of the Council of Academic Societies to immediately initiate support of the Library; (g) reaffirmation of the intent to publish a report of the conference promptly, and to recruit a staff to undertake

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a more substantive effort to determine from the world of medical education the inputs required for optimal planning by the Library. (Dr. Smythe's presentation to the Library on March 24, 1969, stressed the points noted above.)

In further discussion of the NLM project, it was decided that the Steering Committee for the conference should serve as an "editorial committee" for its report. This Committee, upon submission of its report, would be discharged having completed the task to which it was assigned. In the meantime, the Council of Academic Societies would appoint another standing committee on the NLM-BCN development.

Possible individuals to staff this committee and to carry the project forward were discussed.

The failure to activate the Committee on Graduate Medical Education was decried. This Committee is to be asked to meet and to organize itself on Monday, April 21, at the Drake Hotel in Chicago. Drs. Richard Ebert, Leighton Cluff, Halsted Holman, Jay Bollet, and Willis Hurst were mentioned as potential additional members from the field of Internal Medicine.

Two proposals for support for the programs of the Council of Academic Societies from the general funds of the Association were discussed. One was for staff, i.e. a professional, his secretary, and their expense, about \$50,000 a year. A second was for the assignment of dues from individual members of the AAMC to the Council of Academic Societies.

There was more support for the former, although many attractive features of the latter proposal were recognized. Dr. Cooper assured the Committee that once his comprehension of the financial status of the AAMC became clearer, he would set about seeing to it that the CAS received the support its potential importance as an integral part of the AAMC warranted. Dr. Smythe agreed to seek any data available on the allegiances of individual members and what projections for support of the CAS might be derived therefrom.

It was further agreed that until support for additional staff was mobilized, it would not be wise for the CAS to institute additional programs that it could not carry out adequately.

The Committee structure suggested in the minutes of the last meeting was discussed. The need for active productive standing committees on graduate medical education and the NLM-BCN project was reaffirmed as noted above. Until more staff support is available, committees on curriculum, etc. and the economics of medical faculties should be held in abeyance. The need for a nominating committee is self-evident. The CAS will strongly urge on the Executive Council a Committee on Committees or its equivalent.

The need for the CAS to develop a program oriented to the requirements of its component disciplines to make their voices heard in the solicitation of public support for their programs was discussed extensively. It was agreed that this was an item of the highest priority, which should be among

the first responsibilities assigned to the expanded staff, but that anything that can be accomplished in the interim should be initiated now.

The resolution against the indiscriminate drafting of graduate students is to be forwarded to the AAMC Executive Council in an effort to martial more general support for this position.

The history of the resolution in support of biomedical research was received and reviewed as information.

It was agreed that the CAS annual program in Cincinnati, Ohio, should be held on Saturday and Sunday afternoons, November 1 and 2, 1969.

On Saturday afternoon, the central theme will be "The Role of the Sciences Basic to Medicine in the Medical College." Drs. Philip Cohen, Paul Sanazaro, Jacques Barzun, Arthur Kornberg, Eugene Braunwald, Frazier Mustard, Peter Stewart, Dan Tosteson, Sam Clark, Donald Seldin, Lou Welt, Francis Moore, Hollifield Smith, A. Dorfman, and Robert Pitts were suggested as speakers. On Sunday afternoon, the program will be concerned with the business of the CAS with heavy emphasis on the NLM-BCN project. The NLM is to be asked to prepare a working demonstration or exhibit. The agenda will include minutes, reports on or from the Executive Committee, the President of the AAMC, the Treasurer of the CAS, progress reports on the graduate medical education and NLM conferences, and the nominating committee. Reports on pending legislation, minority group admissions, student unrest, and further descriptions of NLM developments may round out the afternoon.

Letters from the American College of Physicians and from others of the specialty colleges seeking sustaining or contributing membership in the Association were discussed by Dr. Cooper. The interrelationship between these applications and the efforts of the Council of Academic Societies were explored.

The major educational drive of such colleges is in continuing education. Accordingly, their entry into the AAMC fold is a commitment toward the development of a more active program in this area. How they interrelate with the CAS is, and will remain, a problem for a short period of time. The Association is not in a position to mount additional programs at this time, nor is the CAS able to expand its scope of work without additional staff. Accordingly, it was decided that the optimal course of action was to respond positively to these letters and to suggest that the Association sit down with the colleges to begin to explore other optimal methods for their interrelationships. A good time to initiate the first of such discussions might be on April 20 at the time of the meeting on Graduate Medical Education at the Drake Hotel.

The meeting was adjourned at 4:00 p.m. It was tentatively agreed that the next meeting will be scheduled for either Monday, June 23, or Wednesday, June 25, in and around the next meeting of the Executive Council. It will probably be held in Washington, D. C.

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ITEM II

TO: Executive Committee of the Council of Academic Societies
FROM: Jonathan E. Rhoads, M.D. and Cheves McC. Smythe, M.D.
SUBJECT: Program - Annual Meeting

Attached is a copy of a letter to Dr. Rhoads which describes a possible program in keeping with the conclusion reached at our last meeting. In subsequent conversations, it was suggested that another timely topic has to do with the effect of full-time systems on the concept of the master clinician. The Council of Academic Societies is now scheduled for three hours of general sessions from 2:00 p.m. to 5:00 p.m. on Saturday and Sunday afternoons, November 1 and 2, 1969. It is suggested that this be split into four 90-minute sessions as follows:

- (1) The University Medical School Interface 180
- (2) Full-Time System Revisited 90
- (3) Report of Ongoing Activities } 90
- (4) Annual ~~Business~~ Meeting } *covered by academy secretary and annual business.*

Suggestions for topics 1, 3, and 4 are covered in the attached letter. For topic 2, speakers concerned with the role of the clinician in full-time systems might be selected. People such as Dr. Benjamin Ejsman, Richard Egdahl, Philip Tumulty, George Schriener, James V. Maloney, Samuel Proger, Arnold Relman, Richard Ebert, and many others come to mind. It might be best to structure sections 1 and 2 as symposia with two or three ~~15-~~ *12-15* ~~20~~-minute papers, followed by 30- to 45-minutes of discussion.

At the meeting on June 25 topics should be identified and a list of suggested speakers for each topic drawn up.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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May 29, 1969

To Jacques Barzuz

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Jonathan E. Rhoads, M.D., Chairman
 Department of Surgery
 Hospital of the University
 of Pennsylvania
 3400 Spruce Street
 Philadelphia, Pennsylvania 19104

Dear Jonathan:

I have been turning over in my mind a potential program for the CAS at the time of the annual meeting. You will remember that at our Executive Committee meeting in Washington which John Cooper attended it was decided that the central theme of the program for Saturday afternoon, October 31, would be "The Role of the Sciences Basic to Medicine in the Medical College." Against this decision, the following nine or ten topics with speakers are suggested. I do hope that prompt and vigorous criticism from you and Dr. Tosteson will result in improvement of this first effort.

1. Advantages and Disadvantages of Organizing a Basic Science Department With Major University-wide Responsibilities. *see Obvil - in Faculty & med*

The thought here is that we might ask someone in charge of a university-wide department to examine what this means, which direction the department is going in, and where its faculty members seem to be most comfortable. I had in mind Dr. Philip Cohen, Professor of Biochemistry from the University of Wisconsin, who feels very strongly on this subject. Other examples are Dr. Crow from the same institution, Dr. Evans in the Department of Microbiology at Washington University (Seattle), one of the distinguished basic scientists from the University of Michigan, or a professor of biochemistry at Harvard where there are both university and medical school departments.

*Ben
 Everett
 has
 recruits.
 Jan - Mich*

2. The Medical School As The Base for A Fully Developed Scientific Discipline.

Here I have Bob Pitts down. Cornell is 200 or more miles from its university, and one could certainly describe Pitts as a complete physiologist.

① Handler

3. Implications for Basic Science Departments in Activation of the Continuum Concept.

Peter Stewart. Brown has in fact approached more closely the continuum concept between college and medical school than anyone else. Stewart is

see Obvil -

Part of section at Chicago

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not the most dynamic person in the world, but he has thought about these things and might do a good job. Other speakers might be chosen from either Boston University or Northwestern.

4. The Clinical Department As A Scientific Critical Mass.

Eugene Braunwald is the first choice as a speaker. San Diego has gone in for science and Braunwald will almost certainly build a scientifically oriented department. Mollifield Smith is a second choice. ~~W. S. Weaver~~ or Wynngaarden will also do very well.

5. A New Look at the Interface Between the Medical School and the University.

Albert Dorfman. Dr. Dorfman is Professor of Pediatrics at Chicago, is a trained biochemist, has been involved in some excellent work in immunology, and yet as a pediatrician is sensitive to other forces in the school. Whether the unique circumstances at Chicago rule him out, I do not know. Paul Samazaro feels very strongly that this aspect of medical education needs another look, but he may be persona non grata to some of our colleagues. We also might not be able to persuade him to speak. There are many people who both could and should deal with this topic.

6. The Hospital As An Adequate Base for Medical Education. Mans Popper. Dr. Popper was as influential as anyone else in bringing Mt. Sinai into being. He has given this a great deal of thought, is an articulate and older man, and is about as well prepared to discuss such a topic as anyone.

7. The University Medical School - A Fact Or An Illusion.

Don Seldin. A large number of the so-called university medical schools in this country have no real affiliation with the university. Southwestern is an example of this and yet Seldin has built a distinguished department.

8. The Students Challenge For Relevance.

Daniel Tosteson. Duke's new curriculum, the record of the school with some involvement with student unrest, Dr. Tosteson's distinguished scientific record, his role in the CAS all make him an excellent choice for this topic.

9. A Student's Challenge For Relevance.

Here I believe we should ask a student who is not in the first or second year, but who is interested in change to attempt to explain to us just exactly what relevance means. Another evidence of the rapidly advancing degeneration of the undersigned's grasp on his faculties is his increasing difficulty in comprehending just what words in the English language mean, especially when they are used by others.

Panel 3 *3 Schools* *2 Students*

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F For Sunday afternoon, November 2, we had decided that the major topic would be the business of the CAS with some emphasis on the National Library of Medicine project.

L As I have not written to you, Dr. Schwartz was not amenable to the formation of a committee to work on this project under any directorship other than his own. Not only was he not amenable to directorship other than his own, but he felt that the fact that we could raise the topic constituted such significant questioning of his ability to run the project that he withdrew on the spot. Since this transaction took only about three sentences, I really think that Bill may have been seeking a way out. At any rate, we do not have his services. I do not have an adequate substitute at this time, and have not come up with a better answer. It is obvious that this requires some more thought and effort, and, hopefully, we can work something out.

F This means that our heavy emphasis on the National Library of Medicine project for the Sunday afternoon program should perhaps be re-thought. With all of this in mind the following suggestions are presented:

C 1. A paper on the implications for graduate medical education of organizing the graduate faculty like the undergraduate faculty is organized, i.e. on a corporate rather than departmental basis. You may remember that this is what your Standing Committee on Graduate Medical Education has asked us to consider. A second draft of a paper will be forwarded to you shortly. Of course, this paper should be followed by a discussion in an effort to identify both weak spots in the argument and those people who might be interested in pursuing this notion. Either Russell Nelson or Bill Holden should be asked to speak, and whichever one agrees, the other should be asked to discuss his remarks.

P 2. Next might come a paper by what hopefully and wishfully thinking might be a staff man on what the CAS is doing and has done or has not done in organizing the various disciplines for their inputs into the policy making processes in Washington.

Y 3. I would suggest a presentation by the American Academy of Orthopaedic Surgeons in which they tell us the story of the organization of the National Program for Orthopaedics, how they went about this, what lessons they learned, and what benefits they see for their profession. Charles Herniman would be the speaker of choice.

4. A paper by Dr. C. J. Gunn discussing what he is doing and plans to do in the National Library viz-a-viz the biological communications network, followed by another paper outlining what will hopefully be a more advanced status of Gunn project by the first of November. This section of the program would then end with or without a demonstration of some sort from the LHM depending upon time.

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Jonathan H. Rhoads, M.D.
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We should then go into a business meeting with reports from the various officers, treasurer's report, elections, and the like.

I

Your reactions are solicited. You will also remember that we have called a meeting of our Executive Committee on Wednesday, June 25, which is the day immediately following the meeting of the AAMC Executive Council. I would appreciate hearing from you as to whether this is still a good plan and if you still wish such a meeting called. I happen to think it is important for a number of reasons, including maintenance of continuity, further input into this suggested program, a further push on graduate education and the ECN, ideas for recruitment of a staff man, and initiation of discussion of possible different approaches to membership in the CAS now that we have had a year or so of experience working the current plan.

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Sincerely yours,

Cheves McC. Saythe, M.D.
Associate Director

CMS:pm
cc: Daniel C. Testeson, M.D.

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ITEM III

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Agenda - 1969 Council of Academic Societies Annual Business Meeting

The following agenda is suggested:

- (1) Call to order
- (2) Roll call
- (3) Minutes - 1968 meeting
- (4) Report of Executive Committee
- (5) Report of Secretary-Treasurer
- (6) Report of Nominating and Credentials Committee
- (7) Other business

In the interval between now and the annual meeting, a note should be sent to the various member societies soliciting their suggestions for items to be added to this agenda.

ITEM IV

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Status of National Library of Medicine Project

Negotiations with Dr. William Schwartz concerning a very active role for him in this project collapsed, irretrievably and unexpectedly on May 15. This was such a surprise that no effective alternate position had been prepared at that time. These events have lost us about two months.

In the meantime, the report of the February conference is coming along nicely and will be completed on or close to our deadline of July 1, 1969.

The Library has secured the services of Dr. C. J. Gunn of the Department of Medicine at the University of Oklahoma for his sabbatical year. Dr. Jerome Lysaught of the University of Rochester is available late in the fall or around the first of the year and is interested in working with us on this project. A changed role in the AAMC for Dr. Smythe opens up the possibility of his devoting a more significant portion of his time to this project than had been thought feasible heretofore. This might be especially true in the next few months.

Dr. Smythe is to spend a half day with Dr. Gunn on June 27 when they will try to define their respective roles and work out a plan of action for the next four months.

The discussions with Drs. Schwartz, Gunn, Cummings, Davis, et al to date led to the conclusion that a potential report might consist of at least four parts:

- (1) Introductory section outlining the current state of the art and describing either experiences with or data from programs now active in medical centers.
- (2) A description of a national resource using techniques now available or known to be shortly available with some comments on possible forms of its organization.
- (3) A review of possible implications for and applications of newer modalities of communication and information storage and retrieval in medical education. This is, in essence, a less conservative or more blue-sky computer oriented chapter.
- (4) A concluding summary section with recommendations and alternates for each.

This proposed format does not eliminate the possibility that the whole project could bog down in an ooze of global generalities. Therefore, at first, planning and identification of proper goals is a very necessary step. For this, a committee staffed by Dr. Gunn and Dr. Smythe is a logical conclusion. There are a number of possibilities for chairman of the committee. The chairman should have a significant voice in the selection of other members.

Once it is decided what data are needed (hopefully this planning step will be completed no later than November 1, 1969, and optimistically, October 1, 1969), the information gathering phase should begin and last for about five months. It is suggested that consultants be used liberally during this period. The last four months of the project should be set aside for the final report.

Dr. Cummings has agreed that the financial terms of the contract can and should be re-negotiated at the end of the planning phase.

Chapman

Scoville

*Jim Maleng
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ITEM V

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: New Staff Position

The 1969-70 budget to be presented to the Executive Council of the AAMC authorizes a new staff position for a professional medical educator who will be expected to spend a significant portion of his energies on the problems of the Council of Academic Societies. Your help in suggesting suitable individuals for such a position is solicited. A more junior than senior person seems appropriate and someone who seeks the advantages of national activity in medical education most logical to approach. A list of some forty names has been drawn up, many of whom are probably too senior. The list will be available for discussion.

*Review
Lynch - 10/14/68*

ITEM VI

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Status of Graduate Medical Education Workshop

Miss Littlemeyer and Mrs. Nelson have pushed the report of this project through to successful preparation of a manuscript which has been submitted to The Journal of Medical Education for publication in September, 1969. A copy of this manuscript has been forwarded to Mrs. Shirley Johnson, Program Management Office, Physician Education Branch, Division of Physician Manpower, the contract officer. Publication of this book will mark the end of this project and of the contract. Logical next steps are outlined in the two agenda items which follow.

ITEM VII

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Corporate Responsibility for Graduate Medical Education

Your Standing Committee on Graduate Medical Education met on April 21 and May 26. They have taken two actions:

(1) Before a Council of Academic Societies position relative to a more active role for the universities in graduate medical education can be strongly pushed, some definition of what is being talked about is necessary. To this end a paper was suggested. A draft of a paper reaching toward a definition of corporate responsibility for graduate medical education is attached. Your reaction to and criticisms of this as well as action by this Executive Committee on the steps outlined on Pages 13 and 14 of this paper are requested.

(2) Your Committee also suggested that involvement in the financing of graduate medical education was best served by active membership on an Association-wide committee concerned with this problem. Mr. McNulty and the Council of Teaching Hospitals have taken leadership in this area. Such a committee has been appointed and representatives from the Council of Deans and Council of Teaching Hospitals suggested. The committee is to meet at the end of this month, and a list of people active in the CAS who might take a significant role in it has been forwarded to Mr. McNulty and Dr. Rhoads.

CORPORATE RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

In the context of this paper corporate responsibility for graduate medical education is defined as the assumption of the classic responsibilities and authorities of a university for its students and faculty by the medical faculty of the university as a corporate group. This implies that the faculty of the medical school will collectively assume the responsibility for the education of clinical graduate students (interns and residents) and that the education of these students will no longer be the sole prerogative of groups of faculty oriented to individual departments.

Among the advantages inherent in vesting responsibility for graduate medical education in a single identifiable body rather than continuing today's fragmentation are the following:

1. Implementation of the continuum concept in medical education.
2. More effective adaptation to individual student's rates of progress through the educational process.
3. Fostering multiple methods for conducting graduate education and thereby enhancing innovation.
4. Enrichment of graduate medical education by bringing to it more of the resources of the university.
5. Promoting the introduction of greater efficiency and flexibility in the use of faculty and facilities.
6. Enhancing the principle of determination over educational programs by the individual universities.
7. Promotion of a comprehensive rather than a fragmented pattern of medical training and practice.

The major drawbacks to such an objective are:

1. The hazard of incurring some of the inflexibilities of university procedures and/or dangers of bureaucratization.

Fragmentation Or The Absence of Corporate Responsibility in Graduate Medical Education

Internship and residency training or graduate medical education is now carried out in hospitals of great variety. Classically, such interns and residents are considered employees of the hospitals although medical schools or other professional groups may contribute to their stipends. In many ways house officers are denied the practice privileges of physicians not in teaching programs, especially as regards the management of fees for services to patients.

In the majority of instances such house officers are pursuing specialty board certification or publicly ascertainable qualification in one of the medical specialties. The duration of training, to a varying extent its content, in part decisions on the rate of progress of an individual through a program, and determination of his eligibility for admission to the specialty board examinations are all determined by the individual Boards. Such Boards are characteristically private, not-for-profit organizations, usually answerable only to themselves and with self-perpetuating directorships. They bear no overt relationships to universities or hospitals.

A variety of agencies examine and/or accredit the programs in which training is carried out. Sometimes the Boards assume this responsibility, most usually indirectly. In other ways the Joint Commission on Hospital Accreditation through its approval of hospitals and, as a generality, the graduate education section of the Council on Medical Education of the American Medical Association through the Residency Review Committees have coordinated other parts of this function. The concern of the Council

on Medical Education for all facets of medical education is a matter of historical record. The relationships between the Council on Medical Education and the Residency Review Committees is a complex one. However, it is to be noted that the American Medical Association has its roots in the practice of medicine, and its policies will inevitably and properly always be strongly influenced by current conceptions of the interests of physicians whose direct contact with education has ended.

The individual to whom the resident is responsible is his service chief, program director, or departmental head. Such an individual always has a major hospital appointment, and his authority over a clinical service, and hence over its residents, relates to his role in the hospital. He may or may not have a university connection of significance, ranging from major to only ceremonial. This service chief has had direct responsibility for the content of the program beyond that demanded by the Boards and for literally all the process through which the residents' education and training is conducted. Although service chiefs may work closely with members of their own departments, insofar as content and process of residency education, such chiefs have been answerable to no one, except for the broadest of hospital policies laid down by the hospital executive committee or its equivalent.

The medical school or university in whose shadow the intellectually significant majority, regardless of numerical considerations, of graduate medical education is carried out undoubtedly exercises very significant influence on the process of graduate medical education. It also has very real authority, exerted primarily through influence over hospital policies by the appointments of service chiefs in which it plays a major or even the dominant role. However, it may or may not have real

operational responsibility. Its faculty as a group has no corporate responsibility. The exceptions, such as that at the Mayo Clinic and the University of Pennsylvania Graduate School, exist in atypical settings.

A further significant fact is that, despite oft repeated disclaimers, specialty board certification does represent a second degree and is the significant license for the higher reaches of American medical practice. The evidence for this allegation is all around us, but is found most importantly in attitudes and behavior of the men in practice and in those who make hospital appointments and decide on professional reward systems, both pecuniary and non-pecuniary. This state of affairs is a significant departure from the usually stated theory of license to practice. In the usual formulation, civil government, because of its obligation to protect the people, grants to agencies which it controls the authority and responsibility to decide who shall be admitted to the practice of a profession. Such agencies characteristically have as their primary charge protection of the best interests of the people. In one fashion or another, through either appointment or election, in the United States they are answerable to state governments. If the specialty boards are indeed de facto licensing agencies, current practices in which they are primarily responsible to their colleagues in their specialties are far removed from usually accepted theories of the nature of civil license.

In summary, control of graduate medical education is fragmented between, (1) hospitals which employ trainees and provide the classrooms and laboratories for their education; (2) specialty boards which determine duration and a portion of the content of training and act as de facto licensing agencies; (3) service chiefs who on a programmatic basis

determine the balance of content and all of the process of graduate medical education; (4) external accrediting agencies which accredit on a programmatic basis and which in the long haul are answerable to the interests of the practicing profession; and (5) medical schools and universities which exert considerable authority through the individuals whom they appoint but accept little direct operational responsibility as institutions.

Before any new arrangement is adopted, in terms of its stated objectives, this pluralistic system has some real advantages. However, the degree of specialization which has been brought about by advancing knowledge calls for parallel evolution of complexity of organization. It is this complexity in fashioning the education of a physician which has created demands for a more holistic approach to the total duration of medical education which a corporate approach in graduate medical education can help provide. The emphasis on major disease and on inpatient care has produced a medical care system with serious imbalances. The failures of ambulatory care and the virtual breakdown in the adequate provision of comprehensive care are both now notorious.

However, today's system has consistently and reliably produced specialists well equipped to care for the disease related content of their areas of medical practice. They are interested in the welfare of their patients as related to their specialties. The fragmented pattern of medical practice the system has helped produce is further evidence of its efficacy, for it was never intended to do anything else. In terms of its goals, it has been an acceptably successful pragmatic solution, adaptable to the variety of conditions found in so large and diverse a nation as the United States. If its goals were now acceptable, its ambiguities would be tolerable.

Unification or Corporate Responsibility in Undergraduate Medical Education

In many ways the situation in graduate medical education today is not dissimilar from that of undergraduate medical education seventy years ago. It is widely recognized that the medical school and its parent university have assumed corporate responsibility for undergraduate medical education. This was the significant reform of 1890 to 1925. The issues facing graduate medical education in 1970 contain many striking parallels and the solution being suggested here has many features of that which worked so well for undergraduate medical education two generations ago.

Corporate Responsibility

Corporate responsibility has been defined for the purposes of this paper as institutional as opposed to programmatic assumption of the classic responsibilities of the university as related to students and faculty. These are seven:

1. Determination of educational objectives and goals.
2. Allocation of resources and facilities to permit realization of these goals.
3. Appointment of faculty.
4. Selection of students.
5. Determination of content and process of educational program.
6. Evaluation of each student's progress.
7. Designation of completion of program.

It is proposed that these responsibilities as applied to ^{graduate medical} education be vested in a university and then delegated to its medical faculty which in turn should create a program of educational advancement protecting the rights of students and attending to the requirements of society.

The medical faculty as a faculty would become the body responsible

for creating the environment for their activities in graduate medical education, selecting their fellow faculty members, and approving the design of programs in graduate medical education including concern for processes used, the duration and content of learning, and the coordination and inter-relation between various units of the faculty. As a faculty, they would have a voice in the selection of students, with concern for their quality and number. They would also be expected to institute procedures which would allow them to determine the readiness of the residents to stand examinations for certification by the currently constituted specialty boards.

Some Thoughts on the Implications of the Acceptance by the Universities of Responsibility for Graduate Medical Education

So many agencies and people would be affected by pulling today's fragmented responsibilities together and assigning to universities both the responsibility and authority for the graduate medical education now carried out in their spheres of influence, that the only way to analyze implications of these changes is to look at the various forces involved one at a time.

The University

The various relations existing between parent universities and their medical schools would not be appreciably altered by this change. This statement applies to administrative, financial, and organizational matters. Long range changes could be expected and these will be touched upon in the following sections.

The Medical School Faculty

There would need to be relatively little immediate change in the day to day climate of the faculties of medical schools. More significant would be the slow but predictable and desirable increase of interaction with other faculties. There would also be a tendency toward greater coordination of activity within the clinical faculty. Presumably, there would be more effective integration of the strengths of various units/^{of the medical center} both medical and non-medical, ^{and this} greater coordination could be expected to produce different educational and patient care alignments. Conversely, the faculties might get caught up in such forms as coursework, credits, examinations, and the like. It is probable that such a move might foster the reappearance of some structured or core curriculum in medicine or surgery early in graduate medical education which could be viewed as a displacement of yet another year of medical school forward. This tendency will appear anyway and is a force with which medical education will almost inevitably have to deal.

The Graduate School

Should such corporate structure be the responsibility of the graduate school? Potent arguments for such an election exist and would certainly surface and result in a not inconsiderable tug of war. However, graduate clinical education is so eminently the business of physicians that it makes little sense to assign its responsibility elsewhere. Immediately there would be a cry that the basic science Ph.D. candidates would have to be reassigned or not reassigned in such a setting. Actually, multiple solutions are possible with Ph.D. candidates remaining with the graduate faculty or reassigned to the medical faculty. Such ambiguities seem tolerable.

Another Degree

The issues of advanced and intermediate degrees in medicine are not trivial. Residents now get unimportant pieces of paper from hospitals (certificates of service) and an important piece of paper from specialty boards (certification of specialty status). The advanced clinical degree has not caught on in this country despite its trial, especially in Minnesota, and despite practices abroad. A corporate arrangement would demand some formal recognition of the end of the educational sequence. A degree of some sort would almost certainly emerge in time, probably in discoordinate fashion from school to school. As an obstacle to a new plan or organization, the degree issue need not be settled early. However, some will advocate a preliminary degree after medical school, perhaps an intermediate degree a year or two later, and some final degree such as master of surgical science or the like as the university's certification of what each graduate student had accomplished. Any move to imperil the strength of the M.D. degree would be very strenuously resisted, and to be effective, thinking would have to be in terms of an additional degree.

Hospitals

Here truly significant problems begin to emerge. The major educational program of a hospital would become the responsibility of an agency in some instances external to the hospital and governed by a different board. This is a significant shift and it can be expected that hospitals everywhere will analyze its implications with their own interests in mind as is only proper. The realities of getting a group of community hospitals

or a community and university hospital to organize a single corporate educational entity will call for intensive bargaining. Perhaps it can be predicted that there will be orders of difficulty from least in a situation in which hospital and medical school are jointly owned and administered by a single board, to most where hospital ownership, operation, financing, and location are all separate. Many of the issues raised will turn around advantages to the hospitals. As far as financing goes, there would be few differences in today's practices. Organizationally, there might be shifts in the influence of single departments. Operationally, this might emerge as another force toward more comprehensive medical care. In terms of accreditation or approval, the hospital educational program would be approved as a unit. This would mean the number, duration, type of training, and coordination of training offered would be returned to local control by the joint medical school-hospital faculty.

The Trainee-The Resident

At first, there would be very few changes for the people in training. However, more ready access to other departments, readier availability of the resources of other units of the university, and better coordination in training could be expected to lead to stronger, shorter, and more varied programs. These would all eventually work to the advantage of the residents, and this type of result for them must be seen as among the major reasons for and major benefits expected from the advocated change. Admission to, progress through, and certification of completion of training would become more formal, less casual, and more subject to general university procedures. To some these changes would appeal; to many others they would not; to the

majority the response would be one of indifference. It should be remembered that these university procedures would carry with them the benefits of easier access to all the strengths of the university.

Dollars

The university probably could not be persuaded to assume responsibility for graduate medical education if an increase in expenses could be predicted. Actually, expenses should not increase except as academic functions increase. Fundamental to this whole proposal would have to be recognition that clinical functions must be funded from clinical sources, and academic functions funded from academic sources. Since this change is so clearly on the way, it should prove little threat. Many variations are possible, almost all of which will evolve around allocations of salary. This is an administrative matter to be settled by each university and its hospital.

The Specialty Boards

The role of the specialty boards would change primarily toward their becoming certifying agencies not exercising direct control over duration or content of training. This again also seems to be a change which in one form or another is clearly on us. Once the Boards clearly understand that a major continuing role would be preserved for and indeed demanded of them in such a unified system, it is reasonable to expect that they will not constitute a significant obstacle.

The Proposed Commission on Medical Education, The Council on Medical Education of The American Medical Association, Residency Review Committees, Joint Commission on Hospital Accreditation, and other such external bodies

All of these agencies exercise to one degree or another a single but important function; that is, of an external accrediting agency. This function must be carried out in order to protect the public. One of the fundamental assumptions surrounding the proposed corporate responsibility for graduate medical education is that the corporate body itself in matters pertaining to accreditation, would relate primarily to a single external agency and be accredited by it. The proposed Commission on Medical Education is an effort to create such an agency at this time. Its emergence remains in doubt, but if the advocated change does not come about, the universities would need and would indeed demand the organization of some external accrediting and standard maintaining body rather than being answerable to many as they are today.

Patients and Consumers

No immediate effect on patients and consumers can be predicted at this time. However, since the *raison d'être* of the whole health care and health education system is to serve the people, the vitality of corporate medical education must eventually rest in its ability to serve the people well. Public input is desirable and has been proposed at a national level. It should be locally determined from medical center to medical center based on local consideration.

Some Models

The undergraduate medical school is the prime model which should be examined. The English hospital school is another model of a sort. The medical center graduate schools (Ph.D. degree granting) are also models.

Mayo, Minnesota, and the University of Pennsylvania Graduate School are models. San Diego may be a model, and city-wide programs such as in Rochester and Buffalo contain some pertinent points. The clinical faculty council at Yale could be seen as a primordial grouping. Every medical school and teaching hospital executive committee contains many of the forces through which graduate medical corporate faculties must evolve, but there is no truly viable model in existence today. The most worthwhile lessons are to be learned by an examination of what happens in undergraduate medical education. Also, there is no external group the equivalent of the Liaison Committee on Medical Education equipped to deal with graduate medical education reorganized on an institutional base. Such an external body is needed.

Positive Steps

There are some positive steps which could be taken now.

Assumption 1: A Commission on Graduate Medical Education has been authorized and is starting to function. Steps suggested below are to be worked out in conjunction with such a Commission.

Assumption 2: A Commission on Graduate Medical Education has not been authorized and is not functioning. Under these circumstances those wishing to organize graduate medical education would have to work with today's fragmented authorities.

From an operational viewpoint, the major difference in the two assumptions is one of time rather than quality.

Proposed steps:

1. Formulation of a statement defining the major features and

- objectives and examining the implications and realities of corporate graduate medical education.
2. Action on such a statement by the Council of Academic Societies Executive Committee and on through the AAMC structure.
 3. Discussion with the Council on Medical Education of the AMA of its responses, attitudes, and inputs.
 4. Solicitation of a university and a medical faculty to explore the proposition and to react to it.
 5. Solicitation of a university teaching hospital to explore the proposition and to react to it.
 6. Beginning interaction with Specialty Boards, the Joint Commission on Hospital Accreditation, the Residency Review Committees, the Association for Hospital Medical Education, either directly or through a Commission on Medical Education if this is possible.
 7. Continued pressure toward finding a medical center willing to work the proposal through its faculty.
 8. Interaction with the Liaison Committee on Medical Education toward setting up institution-wide accreditation procedures in one or two trial settings during the coming year.
 9. Identification of a funding source willing to support evolution of such a project (a) within a medical center or a series of medical centers, (b) within the secretariat for such a development; that is, the AAMC or the Commission on Medical Education.
 10. Identification of likely medical centers with which to begin to work. The potential list includes about 40 schools from which one or two could almost certainly be selected.

These can be summarized in four actions now:

1. Definition of what is meant and objectives sought to be completed and agreed upon prior to overt action.
- 2.a. Identification of a complex willing to explore the proposal.
 - b. Interaction between agencies external to the university medical center.
 - c. Interaction within the university medical center, all of which can and should go forward concurrently and essentially independently.
3. Formal interaction between a hopefully single extra-university and a single intra-university entity.
4. Accreditation - i.e. public recognition of the change.

ITEM VIII

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Commission on Medical Education

You will remember that the Council of Academic Societies went on record last year as favoring formation of a Commission on Graduate Medical Education. In November of 1968 it was proposed that rather than organize a Commission on Graduate Medical Education, a Commission on Medical Education should be organized based in an expanded Liaison Committee on Medical Education. A group consisting of Drs. William Willard, Thomas Brem, Frederick Elliott, Jonathan Rhoads, and Cheves Smythe was asked by the AMA to draft a proposal to be submitted to representatives from the AMA, AAMC, AHA, Council of Specialty Societies, and the Advisory Board for Medical Specialties. This drafting committee worked closely with Dr. Ruhe and many of the suggestions incorporated in the paper which follows have come from him. The committee drew up four alternates and presented these to representatives of the above named groups on April 20, 1969. These representatives voiced their approval of the principles implicit in the proposal for a Commission on Medical Education based on expansion of the Liaison Committee on Medical Education. Drs. Ruhe and Smythe were then asked to re-draft their proposal, approved in principle, and to reduce it to specific enough terms so that its various provisions could be criticized and acted upon by the governing councils of the organizations most directly involved. In a series of meetings of these organizations which are scheduled between now and next winter the meeting of this Executive Committee comes early. This proposal has already been placed before the Liaison Committee on Medical Education, which approved it in principle and recommended that it be forwarded to the Executive Council of the AAMC and to the Council on Medical Education for more detailed study. It has also been discussed by members of your Standing Committee on Graduate Medical Education, who do support it but have made some suggestions basically involving change in wording.

The attached draft of a proposal describes the purposes, authority, function, staffing, and proposed financing of a Commission on Medical Education. As much input into this proposal as is feasible should be elicited at this time, and for this reason it is presented to the Executive Committee of the Council of Academic Societies. It is recommended that this proposal be approved in full recognition of the fact that it would be highly unusual if exceptions to certain provisions of this draft were not taken.

THE COMMISSION ON MEDICAL EDUCATION
A PROPOSAL
FOR ITS ORGANIZATION, COMPOSITION, AND FUNCTION

I Preamble and Introductory Note

A. Preamble

This is a proposal to expand the existing Liaison Committee on Medical Education (of the Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges) to form the Commission on Medical Education which would serve as the central authoritative body for medical education in the United States. The Commission would determine policy and establish standards at all levels of medical education and would coordinate the activities of all organizations that have responsibility for and interest in the various levels of medical education.

B. Introduction

One of the major recommendations of the Citizens Commission on Graduate Medical Education (Millis Commission) was that "a newly created Commission on Graduate Medical Education be established specifically for the purpose of planning, coordinating, and periodically reviewing standards for graduate medical education and procedures for reviewing and approving the institutions in which that education is offered."

In an attempt to determine the desirability and feasibility of implementing this recommendation, the AMA Council on Medical Education invited representatives of four other major medical organizations (the Association of American Medical Colleges, the American Hospital Association, the Advisory Board for Medical Specialties, and the Council of Medical Specialty

Societies) to attend a meeting in Chicago on September 26, 1968. As a result of that meeting, an ad hoc subcommittee was formed, with representation from each organization, to prepare some alternate proposals for the consideration of members of the parent group and subsequent transmittal to their respective organizations.

The subcommittee met five times and eventually submitted four alternative proposals to the parent group on April 20, 1969. Three of the alternates proposed the establishment of a commission or an advisory committee on graduate medical education under various auspices and with varying degrees of autonomy and authority. The fourth alternate, favored by the subcommittee, proposed the establishment of a commission covering all levels of medical education. The parent group approved the fourth alternate with some modification and directed that a revised version be prepared for transmittal to the respective organizations for consideration by their governing boards or councils. This proposal is the revised version prepared by staff in response to that directive.

II Basis for the Proposal

The proposal to establish the Commission is based on several important principles and current practices.

A. Medical education is a continuum from premedical preparation through the continuing education of the practicing physician and is intertwined with education for the allied health professions and services. While there are specific problems at each level of medical education and in allied health education, to have separate bodies that deal separately with these problems without relation to each other would defy the concept of the continuum and would inevitably lead to divergent policies. Accordingly, there

should be a single over-all authoritative body to determine policy and establish standards for the entire field of medical education and for at least that portion of allied health education concerned with the education of those who will provide health care services under the direction or supervision of physicians.

B. Responsibility for medical education and allied health education should be a joint function of the educational institutions and the active profession in concert with representatives of involved facilities. Neither the profession by itself nor the educational institutions by themselves have the balance and perspective which will result in a sensitive and effective response by medical education to the needs of society. The Association of American Medical Colleges is the organization which most completely represents the universities and colleges providing medical education and allied health education. The American Medical Association is the organization which most completely represents the active profession and both are vitally concerned with the production of health manpower for the care of the patient.

C. The Council on Medical Education of the American Medical Association acting alone or in liaison with other groups such as faculties of medical schools and universities, hospitals, and specialty boards, currently serves as the body responsible for coordinating the establishment of educational standards at all levels of medical education and in many allied health areas. It also is responsible for publishing these standards and for maintaining them through its accreditation activities in all areas of medical education. The Council is at the present time the one common denominator for the fields of medical and allied health education.

D. The Association of American Medical Colleges currently serves as a joint body for accreditation of undergraduate medical education and is expanding its interest and activity in the field of graduate medical education and expects to become involved actively in establishing and maintaining standards for continuing medical education and education in the allied health professions and services. As recommended by the Coggeshall Report, AAMC is, therefore, moving to assume responsibility for all levels of medical and allied health education, which will bring it into a position parallel to that of the AMA Council on Medical Education.

E. The Liaison Committee on Medical Education of the AMA and the AAMC has for many years been recognized as the official accrediting agency for undergraduate medical education and is now directing its attention to graduate medical education and continuing medical education. During the current academic year, pilot surveys have been carried out in which, in one instance, a medical school and all of its internship and residency programs were surveyed simultaneously and, in another instance, a medical school and its continuing education program were surveyed. The Liaison Committee is, therefore, already looking ahead to total institutional accreditation involving all levels of medical education. By expanding its current interest, activities, and membership it could readily become a Commission on Medical Education with jurisdiction over all levels of medical education and much of allied health education.

F. Many other organizations currently are active directly or indirectly in the process through which standards at various levels of medical education and allied health education are established and maintained. The interests and activities of these organizations should be respected and should be permitted to continue within the framework of policies established in more

comprehensive fashion. This could easily be done through establishment of committees of the Commission to deal with detailed activities and problems of undergraduate medical education, graduate medical education, continuing medical education, and education for the allied health professions and services. Each organization now involved in or related to education in one of these specific areas would be appropriately represented on the committee functioning in its area of specific interest. The committees in turn would be responsible to the over-all Commission in which shall be vested the final responsibility to coordinate and guide their separate activities to preserve the integrity of the field.

G. The federal government and the public should be appropriately represented on the Commission, and government representatives should participate in the activities of the four committees.

III Name

The name of the organization shall be the Commission on Medical Education. Although it would be technically a broadened and deepened Liaison Committee on Medical Education, the new name would be important to convey the broader authority and jurisdiction of the Committee.

IV Functions and Authority

A. Function

1. The Commission on Medical Education shall elaborate over-all policy and shall publish, maintain, and coordinate educational standards and procedures pertinent to the levels of medical and allied health education within its concern.

2. The Commission shall receive and coordinate recommendations from its various committees and monitor their activities to insure that they are consistent with the policies of the Commission. These committees of the Commission shall act under its jurisdiction so that their activities are consistent with the guiding policies of the Commission.

3. The Commission shall have responsibility for the official accreditation of all levels of medical education. It shall delegate to its committees such procedural authority as shall be advisable and necessary to carry out their responsibilities.

B. Authority

The Commission on Medical Education shall derive its authority from its constituent organizations and from official recognition by bodies such as the National Commission on Accrediting, the U.S. Office of Education, the Bureau of Health Professions, Education and Manpower Training, and various state licensure boards. Since the Liaison Committee on Medical Education

and the AMA Council on Medical Education now have such authority at various levels of medical and allied health education, transfer of this authority to the new Commission on Medical Education can be accomplished easily.

The Commission shall receive and act upon reports from its committees and shall report not less than once a year to its constituent organizations. The constituent organizations of the Commission shall have the right to express approval or disapproval of the policy decisions of the Commission, but shall not retain the authority to veto such decisions. Such policy decisions shall depend on voting procedures to be determined by the Commission.

The presently established authority of other organizations shall continue to be recognized and respected in the activities of its committees within the framework of policy established by the Commission. Similarly, existing liaison relations of AMA and AAMC with other constituent organizations shall continue.

1. This development seems likely to occur eventually under any circumstances since the Liaison Committee on Medical Education is moving rapidly to accept broader responsibilities. The formation of the Commission will facilitate this evolutionary development and bring it more rapidly to an orderly conclusion.
2. In many years of cooperative effort the Liaison Committee on Medical Education has functioned in this fashion with a minimum of interference from its constituent organizations.

V Commission Membership

A. Composition

1. The Commission shall have as its base major and joint representation from the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges.

2. The Commission shall have representation from the American Hospital Association, the Advisory Board for Medical Specialties, and the Council of Medical Specialty Societies, and organizations vitally concerned with various levels of medical education.

3. The Commission shall also have representation from the public and the Federal government.

4. The Commission shall have at least two members selected from time to time on an ad hoc basis by the other members of the Commission to represent areas in which particular problems exist or are anticipated. No ad hoc member shall serve on the Commission for more than three years.

5. With the above principles in mind, the following compositions are recommended:

A total membership of 18, of whom four shall be appointed by the Council on Medical Education of the American Medical Association, four by the Association of American Medical Colleges, two by the Advisory Board for Medical Specialties, two by the Council of Medical Specialty Societies, and one by the American Hospital Association. Additionally, an appropriate federal official such as the Assistant Secretary for Health, Education, and Welfare or his designee shall represent the federal government. Two representatives of the public shall be selected, one each by the AMA and AAMC. There shall be two ad hoc members selected annually by the other members of the Commission.

Except for the representatives of the public and the ad hoc members, all members shall be named by the organizations represented. The term of membership on the Commission shall be three years. No member shall serve for more than two successive terms.

VI Committees of the Commission

A. General Organization and Function

1. There shall be at least four committees of the Commission on Medical Education, one each in the areas of undergraduate medical education, graduate medical education, continuing medical education, and education for the allied health professions and services. Additional committees in other appropriate areas might be established in the future.

2. Each committee shall deal with specific problems within its own area of influence, acting to establish and maintain standards for education in that area. Each shall serve as a working body to prepare and propose statements of essentials for educational programs, and to make decisions concerning accreditation of educational programs within its area, subject to approval by the over-all Commission. While the Commission shall be the official accrediting body for all areas, to each committee shall be delegated the responsibility to act on accreditation matters within its area.

3. Each committee shall relate directly or indirectly to all institutions and organizations having current activities in and interest in the respective fields of education. Active liaison relationships shall be established where desirable.

B. Composition of Committees

The composition of the four initial committees shall be as follows:

1. The Committee on Undergraduate Medical Education shall number 12

members: four members appointed by the Council on Medical Education of the American Medical Association, four members by the Association of American Medical Colleges, two members by the Student American Medical Association, one member by the National Board of Medical Examiners, one member by the Department of Health, Education and Welfare (designated by the Assistant Secretary for Health).

2. The Committee on Graduate Medical Education shall number 14 members: three members appointed by the Council on Medical Education of the American Medical Association, three members by the Association of American Medical Colleges, two members by the Advisory Board for Medical Specialties, two members by the Council of Medical Specialty Societies, one member by the Association for Hospital Medical Education, one member by the American Hospital Association, one member by the National Board of Medical Examiners and one member by the Veterans Administration (designated by the Medical Director).

3. The Committee on Continuing Medical Education shall number 12 members: three members appointed by the Council on Medical Education of the American Medical Association, three members by the Association of American Medical Colleges, two members by the Council of Medical Specialty Societies, one member by the Association for Hospital Medical Education, one member by the National Board of Medical Examiners, one member by the American Hospital Association, and one member by the Department of Health, Education and Welfare (designated by the Assistant Secretary for Health).

4. The Committee on Education for the Allied Health Professions and Services shall number 12 members: three members appointed by the Council

on Medical Education of the American Medical Association, three members by the Association of American Medical Colleges, two members by the Association of Schools of Allied Health Professions, one member by the American Hospital Association, one member by the Council of Medical Specialty Societies, one member by the Department of Health, Education and Welfare (designated by the Assistant Secretary for Health), and one member by the Veterans Administration (designated by the Medical Director).

All members of the committees shall be named by the organizations represented. The terms of membership shall be three years and no member shall be allowed to serve more than two successive terms.

VII Election of Officers

A. Chairman and Chairman-Elect -- During its first four formative years, the Chairman of the Commission shall be named by the American Medical Association and the Association of American Medical Colleges in alternate years as is now the case for the Liaison Committee on Medical Education.

After the first four years, the Chairman shall be elected from the membership of the Commission for a two-year term. He shall not be elected for a second term. To provide continuity of function, a Chairman-Elect shall be elected in the same manner, but he shall not be a representative of the same organization as the Chairman.

B. A nominating Committee of four, with no more than one representative from any organization, and appointed by the outgoing Chairman, shall be asked to bring in at least two nominations for Chairman-Elect at least 15 days prior to the meeting at which the Chairman-Elect is to be elected.

Through appropriate procedures this committee shall also institute the steps necessary to ratify the succession of the Chairman-Elect to Chairman.

C. The same procedures shall apply for the chairmanship and chairmanship-elect of the various committees of the Commission, except that the parent Commission shall elect the Chairman and Chairman-Elect of each of these specific committees from a list of at least two nominees submitted by the respective committees at least 15 days prior to the meeting at which the elections are held.

VIII Staffing

At the outset, the Commission shall be staffed jointly by the American Medical Association and the Association of American Medical Colleges. The secretariat shall alternate annually between the American Medical Association and the Association of American Medical Colleges' staffs as is now the case for the Liaison Committee on Medical Education. During the formative phase, the cost of such staff activity shall be shared by the American Medical Association and the Association of American Medical Colleges, in keeping with the current practices pertinent to the costs of the Liaison Committee on Medical Education.

It should be recognized, however, that AMA currently carries on extensive staff activities in the areas of graduate, continuing and allied health education. Until its own organizational interests and activities grow to match those of AMA in these areas, the AAMC shall not be expected to share equally in the costs of staff activity.

The expenses of the members of the Commission and the members of its

committees shall be the responsibilities of the organizations represented. At the completion of the initial phase, after a full operational level is achieved, the Commission shall construct a budget relevant to its programs and the degree of support it can derive from its constituent organizations. Each organization shall be expected to contribute to this budget on some pro-rata basis, possibly related to the number of its representatives on the Commission. The Commission might derive additional income from its activities as well as from services, grants, or contracts performed for or negotiated with other agencies from time to time. The financial affairs of the Commission shall be accounted for by either the American Medical Association or the Association of American Medical Colleges and a financial accounting shall be by the organization association to the constituent organizations and to the parent Commission at least once a year.

Staffing for the committees of the Commission shall be provided by the American Medical Association and/or the Association of American Medical Colleges in the initial phases depending upon the strengths and talents within the staffs of these two Associations.

IX Operation

The Commission shall meet several times annually depending upon the number of problems and policy matters requiring consideration. Meetings shall be called by the Chairman. Early meetings should be devoted to determination of the nature of the Commission's activities and further details of the inter-relation of its constituent organizations and its four committees. During the initial phases, the Commission would also consider the procedural details necessary for its proper eventual function. In general, the Commission shall deal with broad policy matters and shall coordinate

activities among the various levels of medical and allied health education. It shall also identify areas needing correction or study and shall authorize or recommend whatever action seems indicated.

The committees of the Commission shall be expected to meet several times annually with the possibility that frequent meetings might be necessary to deal with special problems. The Chairmen shall call meetings. The chairmen or their designees shall attend meetings of the Commission to promote coordination of functions and shall report the actions and recommendations of their committees to the Commission and of the Commission to their committees.

X Liaison Relationships

The Commission shall maintain liaison relationships with those agencies now active in the various areas of medical education with which it will be concerned.

A. In the area of undergraduate medical education, working relations with the Association of Canadian Medical Colleges shall continue for survey and accreditation of Canadian medical schools.

B. In the area of graduate medical education several other groups currently play major roles in determining policies and standards.

1. There are 20 Residency Review Committees composed of representatives of the AMA Council on Medical Education and of appropriate specialty boards and specialty societies. These committees act as accrediting bodies for their respective areas of residency training under authority delegated to them by the AMA Council on Medical Education and the corresponding boards and societies. In addition, the Institutional Review Committee of the

American Board of Pathology functions as the review and accrediting body for pathology residencies without AMA representatives. All of these committees shall continue to function after formation of the proposed Commission, but they shall report their actions to the Commission through its Committee on Graduate Medical Education and the Commission shall influence their actions by its policy decisions and recommendations.

2. There are 20 primary specialty boards, autonomous organizations which have profound effect upon graduate medical education through the nature of their requirements for certification. The Advisory Board for Medical Specialties serves as a coordinating agency for the various boards, but without executive authority. The Advisory Board also collaborates with AMA Council on Medical Education, through the Liaison Committee for Specialty Boards, in establishing standards for recognition of new specialty boards. Because of the important role which specialty certification has played and is now playing in influencing medical educational programs, it is proposed that representatives of the Advisory Board for Medical Specialties serve both on the Commission and on the Committee on Graduate Medical Education. Active liaison shall also be maintained between the Commission and the specialty boards through the Liaison Committee for Specialty Boards, which would then serve as a liaison committee of the Commission, through its graduate committee, and the Advisory Board for Medical Specialties. The specialty boards and the Advisory Board shall retain their autonomy and independence after formation of the new Commission, but undoubtedly would be influenced in their activities by the Commission's policy decisions and recommendations.

3. Liaison relations, probably of less formal nature, shall also be

maintained between the Committee on Graduate Medical Education and various other organizations including but not limited to the following:

- (a) The Educational Council for Foreign Medical Graduates.
- (b) The proposed new Commission on Foreign Medical Graduates.
- (c) The Federation of State Medical Boards.
- (d) The Royal College of Physicians and Surgeons of Canada.
- (e) The Canadian Medical Association.

C. In the area of continuing medical education, only the AMA Council on Medical Education has attempted to establish educational standards and carry out accreditation procedures. The Committee on Continuation Education of the AAMC has recommended that the AAMC now participate in this accreditation activity. The Division of Regional Medical Programs of the Department of Health, Education and Welfare, is providing the stimulus and financing for new developments in continuing education. The Association for Hospital Medical Education and many specialty societies and voluntary health agencies are also very active in this field. Ongoing collaborative efforts with these and other organizations, such as those concerned with continuing education in Canada, shall be continued and expanded.

D. In the area of education for the allied health professions and services, accreditation procedures and lines of authority are less well established. Consequently, it is impossible to delineate all of the organizational and administrative relationships for the proposed Commission at this time. However, there are certain allied professions and services in which procedures have been standardized and these can provide a base for further development:

1. The AMA Council on Medical Education now serves as the single common denominator for the accreditation of 10 different allied health educational programs, acting in collaboration with appropriate medical specialty groups and professional associations in each area. Negotiation is now in progress for the establishment of educational standards preparatory to accreditation in several other fields.
2. Survey and review procedures are carried out by liaison organizations of the appropriate medical specialty societies and professional or technical associations (often called "boards of schools") which then report their recommendations to the Council on Medical Education for its approval.
3. AMA's Council on Health Manpower and Council on Medical Education are developing guidelines for procedures with newly emerging allied health groups. Basically, this involves definition of the role and function of the new allied health workers by the Council on Health Manpower and determination of the nature and content of the educational programs to produce such workers by the Council on Medical Education.
4. The recently established Association of Schools of the Allied Health Professions will undoubtedly be an important guiding force in the development of the field and should be represented on the allied health committee of the Commission.
5. The AAMC has recently taken leadership to establish a new Federation of Associations of Schools of the Health Professions, which embraces certain health professions which carry on their educational programs relatively independently. These include dentistry, nursing, pharmacy and veterinary medicine in addition to the allied health professions for which medicine

has provided educational leadership. While it seems unlikely that most of these allied health fields will want to function under the jurisdiction of the proposed Commission, it will be important for the Commission to maintain liaison with them, either through the new Federation or individually and separately.

SUMMARY OF MEMBERSHIP OF COMMISSION
ON MEDICAL EDUCATION AND ITS COMMITTEES

COMMISSION ON MEDICAL EDUCATION - 18

- 4 American Medical Association, Council on Medical Education
- 4 Association of American Medical Colleges
- 2 Advisory Board for Medical Specialties
- 2 Council of Medical Specialty Societies
- 1 American Hospital Association
- 1 Government, Assistant Secretary for Health, Department of HEW
- 2 General Public, 1 each to be selected by AMA and by AAMC
- 2 Ad hoc, to be selected annually by other members of Commission

Committee on Undergraduate Medical Education - 12

- 4 American Medical Association, Council on Medical Education
- 4 Association of American Medical Colleges
- 2 Student American Medical Association
- 1 Department of Health, Education and Welfare
- 1 National Board of Medical Examiners

Committee on Graduate Medical Education - 14

- 3 American Medical Association, Council on Medical Education
- 3 Association of American Medical Colleges
- 2 Advisory Board for Medical Specialties
- 2 Council of Medical Specialty Societies
- 1 Association of Hospital Medical Education
- 1 American Hospital Association
- 1 National Board of Medical Examiners
- 1 Veterans Administration

Committee on Continuing Medical Education - 12

- 3 American Medical Association, Council on Medical Education
- 3 Association of American Medical Colleges
- 2 Council of Medical Specialty Societies
- 1 American Hospital Association
- 1 Association of Hospital Medical Education
- 1 National Board of Medical Examiners
- 1 Department of Health, Education and Welfare

Committee on Allied Health Education - 12

- 3 American Medical Association, Council on Medical Education
- 3 Association of American Medical Colleges
- 2 Association of Schools of Allied Health Professions
- 1 American Hospital Association
- 1 Council of Medical Specialty Societies
- 1 Veterans Administration
- 1 Department of Health, Education and Welfare

ITEM IX

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Council of Academic Societies Constitution and Bylaws

Attached to this agenda item is a copy of the Constitution and Bylaws of the Council of Academic Societies. You will remember that it was decided that our program and these Bylaws should be reviewed at the end of two years and any proposed changes derived from this experience introduced at our second annual meeting.

Two societies have joined and then resigned from the Council of Academic Societies since its inception. These are the American Gynecological Society and, recently, the American Academy of Microbiology. One society, the Association of University Cardiologists, was invited to join and declined. Otherwise, our record has been one of slow but growing participation by the membership. At the end of the second year, we will have published a book, put out one minor report, activated on a shaky basis a major educational project at the national level, backed but not initiated proposals calling for significant reorganization of graduate medical education, and have secured enough support within the general structure of the AAMC to warrant authorization of greater staff effort in the development of Council of Academic Societies programs. These developments have been supported by external financing in the amount of approximately \$130,000.

Against these positive accomplishments there is also a list of non-accomplishments, the most significant of which is failure to involve more faculty members in the Council's activities.

At the time this memorandum is dictated, no change in our organizational pattern is recommended, nor does any step other than augmentation of our ongoing activities seem called for at this moment. However, this Executive Committee should be in a position to report to the membership at the annual meeting this fall that it has reviewed the structure and programs of the Council and is prepared to report its conclusions to their membership.

December 5, 1967

COUNCIL OF ACADEMIC SOCIETIES
OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

CONSTITUTION

Preamble

The Association of American Medical Colleges, in order to provide for greater faculty participation in its affairs, has authorized and brought into being this Council of Academic Societies. This action was taken in response to a broader conception of the role of the Association of American Medical Colleges which was set forth in a 1965 commissioned report to the Association, entitled Planning for Medical Progress through Education, and (written by) Dr. Lowell T. Coggeshall.

The specific objectives of the Council of Academic Societies are to serve as a forum and as an expanded medium for communication between the Association of American Medical Colleges and the faculties of the schools of medicine. This forum should serve to enhance faculty participation in the formulation of national policies to provide for the whole span of medical education. The mechanism of communication shall include election at appropriate intervals of representatives to serve on the Executive Council of the Association of American Medical Colleges.

ARTICLE 1.

The name of this organization shall be the Council of Academic Societies of the Association of American Medical Colleges.

ARTICLE 2. Part 1 - Constituent Societies

Section 1. The Council of Academic Societies shall be composed of societies which have an active interest in medical education.

Section 2. A society may either seek or be invited to become a constituent society of the Council of Academic Societies.

Section 3. An initial group of scientific societies (see Appendix A) was invited by vote of the Executive Council and Institutional Members of the Association of American Medical Colleges to join the Council of Academic Societies and to send 2 representatives. All accepted the invitation.

Section 4. In the future, additional societies will be nominated as constituent societies of the Council of Academic Societies by vote of two-thirds of the members present at a duly constituted meeting of the Council of Academic Societies, provided that notice of the proposed nominations shall have been circulated to the members at least one month in advance of the meeting. The nomination of new constituent societies after being passed upon by the Council of Academic Societies, will be sent to the Executive Council of the Association of American Colleges, and to the Institutional Membership of the Association of American Medical Colleges for ratification.

ARTICLE 2. Part 2 - Composition of the Council of Academic Societies

Section 1. Representatives of Societies

Each constituent society will be invited to designate 2 representatives who will be members of the Council of Academic Societies.

Section 2. Members-at-Large

A number of individuals not to exceed 10 who are not chosen representatives of constituent societies but who have special interests and competence in medical education may be elected to membership in the Council of Academic Societies by the chosen representatives of the constituent societies as defined in the bylaws. Election to membership at large shall require approval of two-thirds of those present and voting at such elections.

ARTICLE 3.

Any constituent society may withdraw at its discretion. Involuntary termination of participation by a scientific society which has been elected to the Council of Academic Societies shall occur only after a two-thirds vote of all members of the Council after 30 days prior notice of the proposed action, followed by a two-thirds vote of the Executive Council of the Association of American Medical Colleges and the necessary ratification by a majority of the Institutional Members.

ARTICLE 4.

The method of selection of representatives by each constituent society shall be the sole responsibility of that organization. The term of office of chosen representatives and of members-at-large shall be two years but no individual is to serve more than four such consecutive terms.

ARTICLE 5.

Individuals elected as officers of the Council of Academic Societies or as members of the Executive Council of the Association of American Medical Colleges representing the Council of Academic Societies may hold their membership on the Council of Academic Societies, ex-officio, even though they may be succeeded by new representatives from their constituent organizations. (See below under Articles 6 and 10).

ARTICLE 6.

Officers

A Chairman, a Chairman-Elect and a Secretary-Treasurer shall be elected annually by the Council of Academic Societies. A nominating committee of 7 members shall be selected by a mail ballot from all members of the Council with each being asked to vote for 7 persons. The 7 members who receive the largest number of votes will constitute the nominating committee and shall bring in the names of 2 candidates for each office whom they recommend and who they have ascertained would be willing to serve if elected. The only exception is the Chairman who would ordinarily be the Chairman-Elect from the previous year. Election shall be by written ballot at the annual meeting. The term of office of the Chairman and Chairman-Elect shall be approximately one year, from one annual meeting to the next. Officers shall begin their terms following the annual meeting of the Association of American Medical Colleges and serve until the end of the next annual meeting of the Association. The Secretary-Treasurer may not serve for more than two years following the expiration of his term as a representative of a constituency.

ARTICLE 7.

Section 1. Duties of Officers

The Chairman shall preside at all meetings. He shall serve as chairman of the Executive Committee and shall be an ex-officio member of all committees. He shall have primary responsibility for arranging the agenda of meetings, provided that no question which 5 or more members desire to have placed on the agenda shall be omitted, and provided that there shall be at each meeting an opportunity for items of business to be introduced from the floor for action at a subsequent meeting.

Section 2. Duties of the Chairman-Elect

The Chairman-Elect shall act as a Vice-Chairman and assume the duties of the Chairman whenever the latter is absent or unable to act. He shall also keep in close touch with the affairs of the Council of Academic Societies and shall be an ex-officio member of all committees, except that on nominations.

Section 3. Duties of the Secretary-Treasurer.

The Secretary-Treasurer shall be responsible for keeping the minutes of meetings, a roster of members, sending out notices of meetings, and notifying the constituent societies of the need for selecting their representatives. He shall receive and review periodic reports from the business office of the Association of American Medical Colleges. He shall be entitled to inspect the books of original entry for deposits and expenditures of the Council. He shall be invited to review the results of the annual auditor's report with the auditing agency of the Association of American Medical Colleges.

ARTICLE 8.

The Executive Committee

The Executive Committee shall be elected by written ballot at the annual meeting and shall number 9; the 3 officers of the Council of Academic Societies, and 6 other members, 2 of whom will serve as representatives to the Executive Council of the Association of American Medical Colleges. These 6 members are to be elected for 2 year terms on a staggered basis. The Executive Committee initially elected shall determine by lot or other appropriate impartial mechanisms the terms allotted to its members. Members may succeed themselves for 2 additional terms. The officers of the Council of Academic Societies shall serve as officers of the Executive Committee. The Executive Committee shall take interim actions between meetings of the Council subject to ratification by the Council at its next meeting, unless expressed authority has been granted at a prior meeting of the Council to the Executive Committee to act for it in a specific matter.

ARTICLE 9.

Such other standing or ad hoc committees may be established as proposed by vote of the Council or of its Executive Committee acting between meetings of the Council. Members and chairmen of such committees will be named by the Chairman of the Council unless the names are a part of the motion establishing the committee. In the case of standing committees, membership on the committee will end with the expiration of the term of the member on the Council. In selecting a replacement, the Chairman of the Council of Academic Societies may appoint any member of the Council. Members of ad hoc committees may be selected from the academic community-at-large.

ARTICLE 10.

Times of Meetings

The Council of Academic Societies shall meet during or within 2 days of the annual meeting of the Association of American Medical Colleges and at such other times as may be defined in the bylaws. Notice of meetings shall be defined in the bylaws.

ARTICLE 11.

A quorum shall number 15 members or 25 percent of the Council, whichever is the larger.

ARTICLE 12.

Election of Representatives of the Council of Academic Societies to the Executive Council of the Association of American Medical Colleges

Four members of the Council of Academic Societies shall be elected to serve as its representatives on the Executive Council of the Association. Two of these shall be the Chairman and the Chairman-Elect of the Council of Academic Societies. As a general rule, 2 of the 4 members shall be from societies which are primarily concerned with preclinical disciplines, and 2 from societies primarily concerned with clinical disciplines. Elections shall be for two-year terms, so staggered that 1 clinical representative and 1 preclinical representative shall be elected each year. The same nominating committee as that employed in the nomination of officers will be asked to

bring forward nominations for the unfilled positions at each annual meeting. Two available candidates shall be named for each post and election will be by written ballot of the members present at the annual meeting. Those elected will take office after the annual meeting of the Association of American Medical Colleges occurring at the time of the meeting of the Council of Academic Societies and will serve until the completion of the second annual meeting thereafter. Any duly selected representative serving on the Council of Academic Societies or an officer of the Council who might remain as a member, is eligible for election.

ARTICLE 13.

The Council may not incur debts or enter into commitments by accepting restricted funds or otherwise, which could become obligations of the Association of American Medical Colleges except by specific authorization of the Executive Council of the Association.

ARTICLE 14.

Mechanisms for activity in the affairs of the Council of Academic Societies by individual members of the constituent societies may be provided in the bylaws.

ARTICLE 15.

Amendments

During the first 2 years of its existence this Constitution may be amended by a simple majority of the members present at the annual meeting. Subsequently, this Constitution may be amended by a two-thirds vote of the members present at the annual meeting, provided that the substance of the proposed amendment has been circulated in writing to the members not less than 30 days prior to the meeting.

CMS:es

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APPENDIX A

SCIENTIFIC SOCIETIES, NOW MEMBERS OF THE COUNCIL OF ACADEMIC SOCIETIES

American Association of Anatomists
Association of University Anesthetists
Association of Professors of Dermatology
Association of Professors of Medicine
Association of American Physicians
Association of Professors of Obstetrics and Gynecology
American Gynecological Society
Association of University Professors of Ophthalmology
Society of University Otolaryngologists
American Association of University Professors of Pathology
Association of Medical School Pediatric Department Chairmen
Association of Teachers of Preventive Medicine
Association of Chairmen of Departments of Psychiatry
Association of University Radiologists
Society of Surgical Chairmen
American Surgical Association
American Society of Biological Chemists, Inc.
American Academy of Microbiology
American Neurological Association
American Physiological Society
American Association of Pathologists and Bacteriologists
American Pediatric Society

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COUNCIL OF ACADEMIC SOCIETIES
OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

BYLAWS

ARTICLE 1.

Section 1. In addition to the annual meeting prescribed by the Constitution, there shall be at least 1 additional meeting each year. Such additional meetings shall be held at such times and places as may be decided by the Council of Academic Societies; whenever feasible these will be held in conjunction with other activities of the Association of American Medical Colleges. In addition, meetings may be called at the discretion of the Executive Committee of the Council of Academic Societies or at the request of 15 or more members of the Council. Notices of meetings shall be mailed to the last known address of each member of the Council, not less than 30 days prior to the date set for the meeting.

Section 2. In the case of the 2 regularly scheduled meetings, it shall not be necessary to give advance notice of items on the agenda except for amendments to the Constitution, the election of additional constituent societies, members-at-large, and nomination of officers.

Section 3. In the case of especially called meetings, the agenda shall be set forth in the notice of the meeting and action on any other item introduced at the meeting shall require ratification, either by a two-thirds mail vote following the meeting or must be held over for a majority vote at the next regularly scheduled meeting.

ARTICLE 2.

Section 1. A reminder shall be sent to the appropriate officers of the constituent societies in January of each year, notifying them that they are entitled to 2 representatives on the Council and stating that their present representatives will continue to serve until the Secretary-Treasurer has been notified of a successor who will take office following the next annual meeting of the Council. In the event of the death or disability of a representative, his society will name a successor to complete the unexpired term.

Section 2. For purposes of electing the nominating committee, the Secretary-Treasurer shall send to the members of the Council, on or about July 1, the names of all of the representatives then serving on the Council with a request that each member indicate the 7 persons he thinks best qualified to serve as members of the nominating committee. The ex-officio members, that

is, the officers of the Council and its representatives to the Executive Council of the Association of American Medical Colleges are eligible to serve on the nominating committee with the exception of the Chairman-Elect. Fifteen days will be allowed for the return of the ballots; any ballots postmarked after 15 days from the time that they were mailed will not be counted. The 7 persons receiving the largest number of votes will constitute the nominating committee. In the event of a tie, it will be broken by the officers in the manner providing the best balance between preclinical and clinical interests. The member receiving the highest number of votes will serve as Chairman of the nominating committee.

Section 3. The nominating committee shall nominate 2 individuals for each office and an appropriate number of members-at-large as specified in the Constitution at least 3 weeks prior to the annual meeting. In the event of a tie, it will be broken by vote of the Chairman, Vice-Chairman, and Secretary-Treasurer, whose votes will be secret.

ARTICLE 3.

Dues. Each constituent society shall pay dues of \$100.00 for the first year, and thereafter, recommendations for dues shall be made by the Executive Committee and acted upon by the Council at the time of the annual meeting. Failure to pay dues for two consecutive years will constitute grounds for termination of the constituent society's membership.

ARTICLE 4.

Accounts. The funds of the Council shall be deposited with the Association of American Medical Colleges in a special account which may be drawn upon by any of the 3 officers of the Council of Academic Societies in accordance with action taken by the Council. Expenses in connection with meetings may be paid by the Secretary-Treasurer without specific authorization but shall be reported to the Council. The constituent societies shall be responsible for the travel and per diem expenses of their representatives, except as it may be determined by the societies that their representatives will utilize other funds for this purpose. Actual and necessary living and travel expenses will be paid from the funds of the Council in the case of officers no longer serving as representatives of constituent societies.

The funds of the Council shall be audited annually in accordance with the practices of the Association of American Medical Colleges; a report will be filed by the Secretary-Treasurer and incorporated in the minutes. The Council may also receive funds from the parent organization, the Association of American Medical Colleges, or any other source. The acceptance of such funds and the restrictions pertaining thereto will be by vote subject to Article 13 of the Constitution.

ARTICLE 5.

Members-at-Large. Members-at-Large may serve as officers if elected but not more than 1 such member-at-large may be nominated for each office. Nominations will be made for members-at-large by the nominating committee or by 15 or more chosen representatives to the Council if this is submitted in writing to the Secretary-Treasurer not less than 6 weeks prior to an annual meeting. Such nominations are to be circulated not less than 30 days prior to the meeting. Elections of members-at-large will be conducted only at regularly scheduled meetings. If the number of nominations exceeds the maximum number of places, those receiving the largest number of votes will be elected. Ties are to be broken by secret ballots cast by the 3 officers.

ARTICLE 6.

Amendments. Amendments to the bylaws may be made at any stated meeting or at a special meeting called for the purpose by a two-thirds vote of those present, provided there is a quorum in attendance.

ITEM X

TO: Executive Committee of the Council of Academic Societies
FROM: Cheves McC. Smythe, M.D.
SUBJECT: Applications for Membership of Additional Societies

During the year, eight applications for membership from additional societies have been received. Six are complete and are summarized on the attached sheets and a final recommendation made on each sheet. You will remember that this Executive Committee has elected to serve as a Credentials Committee of the Council. These applications are put before you at this time so that the review process for membership might be initiated. You will also remember that at your meeting on October 2-3, 1968, the following statements were drawn up concerning membership in the Council:

"The major orders of business were the election of new societies and the elaboration of policies relevant to the number of societies to be admitted to the Council of Academic Societies. It was concluded that:

- (1) The CAS recognize the validity of the assignment to it of 35 votes in the Assembly of the AAMC.
- (2) It would not be wise for the Council to seek an increase in this representation at this time or in the foreseeable future.
- (3) The Council should not attempt to limit its membership to 35 societies.
- (4) The Council will continue to admit societies on the basis of the relevance of their programs to the overall programs of the Council.
- (5) This Council recognizes the need to formulate steps through which 35 representatives can be selected from a population of societies in excess of 35.
- (6) Since the number of member societies will not exceed 35 before 1969-70, measures for determining representation should be developed during this 'peaceful interval.'

"The Committee further agreed upon the following working definition of an academic society:

An academic society is defined as an organization which in the opinion of the CAS emphasizes as a criterion for membership, appointment to a medical school faculty or that has a major commitment to medical education.

"In addition to this definition, inquiries from societies seeking membership should be answered by requiring that to be eligible for membership they must have a constitution,

bylaws, and officers, they should be prepared to submit a copy of the program of their last meeting, a copy of its minutes, a statement of the criteria for selecting members, and a membership list."

1. Name of Society

American Academy of Physical Medicine and Rehabilitation

2. Purpose

Promote art and science of medicine and betterment of public health through an understanding and utilization of the functions and procedures of physical medicine and rehabilitation.

3. Membership

Six classes - active, associate, senior, honorary, corresponding, inactive associate

For election to active membership - diplomate of and continued certification by the American Board of Physical Medicine and Rehabilitation.

4. Number of Members

519 active; 108 associate; and 25 miscellaneous

5. Constitution and Bylaws available

6. Minutes Board of Governors and of program of meeting available

7. Organized

1938

8. Recommendation - Disapproval ✓

1. Name of Society

American Association for Thoracic Surgery

2. Purpose

To encourage and stimulate investigation and study that will increase the knowledge of intrathoracic physiology, pathology and therapy; to correlate such knowledge, and disseminate it...to hold at least one scientific meeting each year...to publish a journal.

3. Membership

Active, associate, senior, honorary. Candidates for membership shall have achieved distinction in the thoracic field or shall have made a meritorious contribution to knowledge pertaining to thoracic disease or its surgical treatment.

4. Number of Active Members

400; other classes unlimited

5. Constitution and Bylaws available

6. Minutes and programs of meetings available

7. Organized

1920

8. Recommendation - Another distinguished surgical specialty society. According to past practices, this application should be approved and election recommended.

W. L. ...

1. Name of Society

Association of Anatomy Chairmen

2. Purpose

To provide a forum for discussion and a medium for communication among chairmen of departments of anatomy or the equivalent organizational units in American schools of medicine or approved related organizations in order to foster their common concerns in medical education and research.

3. Membership

Chairmen and acting chairmen of departments of anatomy or equivalent organizational units in AAMC member schools.

4. Number of Members

About 100

5. Constitution and Bylaws available

6. Minutes and programs of meetings

For meetings on 1/31/69 and 3/31/69 available

7. Organized

January 31, 1969

8. Recommendation - Approve application and recommend election.

Approved

1. Name of Society

Association for Hospital Medical Education

2. Purpose

This Association is founded in the belief that sound medical education programs in hospitals result in an improved level of patient care and that such programs are necessary on a continuing basis.

This Association exists to accomplish its stated aims by:

- a. Nurturing sound programs of graduate and post-graduate medical education in hospitals.
- b. Providing a forum for the free exchange of ideas and mutual action on problems common to those individuals responsible for the direction and development of medical education programs in hospitals.
- c. Convincing by persuasion and example the medical staffs of hospitals, regional medical societies, hospital administrators and hospital trustees of the value and necessity of formally organized and directed educational programs to achieve and maintain the highest standards of medical care.
- d. Working in cooperation with other groups to further the development of graduate and continuing education in medicine.

3. Membership

Active members- Any individual having a doctoral degree who devotes a substantial amount of his professional effort to programs of medical education that are directed towards improved patient care and that function in one or more hospitals, is eligible for active membership. Active members are eligible to vote and hold office in the Association.

4. Number of Members

506 active; 200 applications pending

5. Constitution and Bylaws available

6. Programs and minutes of Executive Committee available

7. Organized

October 4, 1968, but it represents a continuation of the Association of Hospital Directors of Medical Education which is at least 10 years old.

8. Recommendation - This is the most difficult application we have to process. Its approval is not recommended until policy toward the major colleges is established.

W/O

1. Name of Society

Association for Medical School Pharmacology

2. Purpose

To foster best possible contribution of pharmacology in medical education

3. Membership

The membership will consist of one representative from each medical school in the United States of America. Invitation to membership will be extended to the head or the acting head of the department or subdepartment of pharmacology in each medical school, or, where there is no such person, to a person chosen by the dean of that school to represent pharmacology in this association. A member may designate as his substitute a member of the faculty of the medical school represented by the member.

4. Number of Members

About 100

5. Constitution and Bylaws available

6. Minutes and agenda of meeting held 4/14/69 available

7. Organized

April 14, 1969

8. Recommendation - This is the chairmen's organization in pharmacology with which we have been in contact for two years. Approve application and recommend election.

OK

1. Name of Society

Society of Teachers of Family Medicine

2. Purpose

Advance medical education; develop multidisciplinary instructional and scientific skills and knowledge in the field of family medicine; to provide forum for interchange of experiences and ideas; encourage research and teaching in family medicine.

3. Membership

Any physician who holds an "academic title" and/or is engaged in the instruction of medical students or house staff...on payment of dues. Also, on any applicant not possessing the above qualifications but actively involved in the organization, teaching or promotion of family medicine on receipt of application and payment of dues.

4. Number of Members

100

5. Constitution and Bylaws available

6. Minutes of meeting and program available

7. Organized

October 27, 1967

8. Recommendation - This organization qualifies save its qualifications for membership. The AAMC qualification for individual membership reads, "any persons who have demonstrated over a period of years a serious interest in medical education." A review of the addresses of members suggests that 47 have university appointments, 14 are based in affiliated hospitals, and 40 cannot be accurately classified from their addresses. This application should be carefully discussed by the Executive Committee.

Refer

1. Name of Society

American Gastroenterological Association

2. Purpose

To foster the development and application of the science of gastroenterology by providing leadership and aid in all aspects of this field, including scientific communication, research, teaching, continuing education and patient care. For the accomplishment of these purposes, to solicit and receive donations and dues; to receive, manage, invest and reinvest real and personal property, money and securities; and to disburse monies and assets for activities in keeping with the stated purposes.

3. Membership

Honorary, affiliate, active, and associate. No conditions for membership are stated, but it is implied that activity in the field of clinical gastroenterology and certification by the Specialty Board of Gastroenterology are necessary.

4. Number of Active Members

Approximately 800.

5. Constitution and Bylaws available

6. Minutes and program of meeting available

7. Organized

1898

8. Recommendation - This is another of the clinically oriented specialty groups such as that in dermatology and in physical medicine and rehabilitation. According to our past practices, this application for membership would be denied.

Inquiries received from:

Plastic Surgery Research Council

Society for Pediatric Research

Applications not completed.

Joseph M. Merrill ✓	Baylor
Malcolm Watts	U.C.S.F.
R. C. Lewontin	Chicago
Morton Bogdanoff ✓	Duke
John Long ✓	Duke
R. E. Jewett ✓	Emory
Thomas Bartley	Florida
Hugh Bennett	Hahnemann
Michael McGarvey for suggestions	NIH
Frank Moya	Miami
Robert Green ✓	Michigan
R. A. Ulstrom	Minnesota
Jack Colwill ✓	Missouri
Philip Anderson ✓	Missouri
Ed Petersen	Northwestern
Robert Bird ✓	Oklahoma
George Knabe	South Dakota
Phil Manning ✓	U.S.C.
W. P. Barba	Temple
Joe Tupin	Galveston
Donald Duncan	Galveston
Philip Montgomery	Dallas
Robert Sparks ✓	Tulane
Robert Coon ✓	Vermont
Edward Wood ✓	Pennsylvania
Augustus Swanson	Washington

Morton Levitt ✓	Wayne State
Robert Coye	Wisconsin
Carl Hinz	Connecticut
Richard Mannegold ✓	RMP
Pat Storey	Hahnemann
Clifford Gurney ✓	Rutgers
Harvey Estes	Duke
John Ballin ✓	AMA
Harold Margulies ✓	AMA
Reginald Fitz	New Mexico
S. Frazier ✓	P & S
Joseph Gonnella	Jefferson
Jack Walker	Kansas
Eugene Lindberg	Maryland
Paul Neal	Richmond
John Peterson	Loma Linda
Richard Schmidt	Florida
Gordon French	Pennsylvania
T. A. Farmer	Alabama

Chamberlain *Pelle - Hepburn - West Va*