# AGENDA

of the

# EXECUTIVE COMMITTEE

# COUNCIL OF ACADEMIC SOCIETIES

Friday, June 12, 1970
9:00 a.m. - 5:00 p.m.

Conference Room
The Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C.

# AGENDA

| | | |
|---|---|---|
| 1. | Minutes of the March 19, 1970 Meeting | A |
| 2. | Report of Nominating Committee | B |
| 3. | Report of By-laws Committee | C |
| 4. | Election of New Member Societies | D |
| 5. | Dues | E |
| 6. | Involvement of More Individuals in Affairs of Council | F |
| 7. | 1970 Annual Meeting Program | G |
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a) Biomedical Research Policy

b) Physician's Assistants

c) National Library of Medicine

d) Graduate Medical Education

MINUTES
CAS EXECUTIVE COMMITTEE
March 19, 1970

AAMC Headquarters
Washington, D. C.

Present: Committee Members
Dan C. Tosteson, Chairman (Presiding)
Sam L. Clark
Harry A. Feldman
Charles Gregory
Thomas Kinney
James V. Warren
William B. Weil, Jr.

Staff Members
Mary H. Littlemeyer
Cheves McC. Smythe

Absent: Committee Members
Patrick J. Fitzgerald
Jonathan E. Rhoads

Present for a portion of the meeting
John A. D. Cooper
John Danielson
Henry van Zile Hyde
Joseph Murtaugh

The meeting was called to order. The minutes of the last meeting were approved as circulated.

Program Schedule

There was considerable discussion of the tentative outline of the Council of Academic Societies Program for the 1970 annual meeting. Its format outlined in the agenda was supported. Specifically, the Council of Academic Societies Executive Committee will meet on Thursday afternoon with a dinner meeting if necessary to follow. The Department of Academic Affairs CAS reception will be held that evening. An effort will be made to stimulate meetings of the various professorial societies on either Thursday afternoon or evening or Monday. The program scheduled for Friday afternoon October 30 from 2-5 p.m. will be described below. The CAS business meeting will be scheduled for Saturday afternoon October 31 and will include reports of the Biomedical Research Policy Committee and the National Library of Medicine project. It is expected that these reports and the regular business will require all of Saturday afternoon.

Program Content

It was agreed that the program should center around the education of non-physician persons who will participate in the delivery of primary health care. Finally in broad outline the following was agreed upon.

Title - Brass Tacks vs. Hot Air for Primary Care

General Format - A presentation by someone actively involved in primary health care in which he describes his personnel needs; this will be followed by a presentation by an educator charged with devising curricula for training such personnel.

Suggested Pairings

1. The needs of a community hospital emergency room contract physician vs. Dr. Cuthbert Owens, University of Colorado.

2. A physician in charge of a large prepaid program vs. Dr. E. Sayward, University of Rochester School of Medicine.

3. An OEO ghetto type community health center director vs. a professor in a medical school in a city in which the health center is located.

4. Someone from a general practice group vs. Dr. Lynn Carmichael of Miami or Clifford Gurney of Kansas.

5. A prosperous internist vs. a professor of medicine (full-time).

6. A trainer of physician's assistants vs. an advocate lawyer.

After discussing these and other possibilities the Committee decided that not more than three such pairings should be programmed for a given afternoon and that they should concentrate on physicians rather than their assistants. Those who seemed to receive most support were; (1) A general practitioner vs. a professor committed to training people for general practice, (2) A prosperous internist vs. a professor of medicine, (3) A physician in charge of a prepaid group vs. Dr. Sayward, (4) A community hospital emergency room administrator vs. Dr. Owens. The staff is to draw up a list of potential speakers and to forward it to Dr. Tosteson. An appropriate program will then be organized.

Pattern of Funding of the Council of Academic Societies and Member Societies Dues

The general consensus reached was that member societies should be billed in units of $500, 750, or 1000. Such billings should be determined by the function of the society (Professorial as opposed to professional) and its size. For some of the larger colleges the amount to be contributed will be left open-ended. The staff will draw up a schedule of proposed charges. Any change in dues will have to await the annual meeting which will permit the Executive Committee to study a variety of proposals.

It was decided that the activities of the Biomedical Research Policy Committee would continue to be supported from available general funds but that a proposed schedule of its funding would be discussed at the April 3 meeting.

Nominating Committee

The memorandum from Dr. R. Howard concerning the Nominating Committee was discussed. It was agreed that the election of the CAS Nominating Committee be put in motion at this time although the reaction of the Executive Committee should be recorded as opposed to any abrogation of the selection of its representatives to the AAMC Executive Council by the Council of Academic Societies.

Other Reports

Dr. Henry van Zile Hyde joined the Committee for lunch and requested its help in finding positions for foreign scholars wishing to come to the U.S.A. It was agreed that such requests could be forwarded from the offices of the Association to the secretaries of the member societies of the Council.

Mr. John Danielson and Dr. John Cooper joined the Committee to describe ongoing efforts in relation to the support of teaching hospitals especially as related to the Medicare-Medicaid issue. The preliminary drafts of various position papers circulated by Mr. Danielson's office were discussed. It was suggested that these should be forwarded to the Boards for their reactions as well as to the professorial societies. Response from these groups could be helpful. This might be done under an appropriate memorandum prepared for Dr. Tosteson's signature. It was also suggested that the CAS should draw up a list of people in the various societies who are available to serve on important ad hoc committees of the Association.

Graduate Education Committee

It was agreed that subsequent to the surveys of West Virginia, Texas - Galveston, Oklahoma, and Utah, a report would be made to the Graduate Education Committee. Other inputs to this Committee should include the development in the Liaison Committee on Medical Education of the Commission on Medical Education. The Committee should be expected to meet again sometime during the summer but prior to firm commitments for the 1970-71 accreditation program.

Structure and Function of the Council

Dr. Sam Clark pointed out that it is meaningless to align the Council in some structure without paying attention to the exact functions that will be served by such an alignment. Therefore, Dr. Clark felt that continuation of the task group-ad hoc approach which has marked the activities of the Council to date is optimal. Complex structural patterns were not supported. It was suggested by Dr. Tosteson that the Council be divided into two panels, one of professorial societies and the other of professional societies. Dr. Kinney suggested that an additional panel of institutional societies be added through which those desirous of forming faculty groups could enter the activities of the Council. It was further suggested that the membership of the Council be expanded to include all the members of the Executive or Senior Committees and the officers of all member societies. From this group and/or determined by each society two representatives to the Council would be selected. These 35 representatives would be the voting members of the Assembly. The apportionment of the 35 available votes through the three panels would have to be determined by experience. The Bylaws Committee, assisted by staff, is to work out further details of this general proposal and present them at the next Executive Committee meeting.

Future Meetings

The next meeting of the Executive Committee is scheduled for Friday, June 12, at 9:00 a.m. at the Association headquarters, One Dupont Circle, N.W., Washington, D.C. The Committee also agreed to schedule a meeting at 3:00 p.m. on Thursday, October 29, in Los Angeles.

TO: Executive Committee of the CAS

FROM: Staff

RE: Report of Election of Nominating Committee

In mid May, the procedure called for by the constitution and bylaws for the election of the nominating committee was activated.

Below is the list of those men who received the most votes:

| | Name | No. of Votes |
|---|---|---|
| 1. | Dr. Charles A. Janeway | 14 |
| 2. | Dr. James V. Warren | 12 |
| 3. | Dr. Charles F. Gregory | 11 |
| 4. | Dr. Eugene A. Stead, Jr. | 10 |
| 5. | Dr. Daniel C. Tosteson | 10 |
| 6 & 7. | Dr. Sam L. Clark, Jr. | 9 |
| | Dr. Richard H. Egdahl | 9 |
| | Dr. Thomas D. Kinney | 9 |
| | Dr. Louis G. Welt | 9 |

ATT. C

TO: Executive Committee of the Council of Academic Societies

FROM: Staff

RE: Report of By-laws Committee

Dr. Sam Clark has chaired a committee to re-examine the by-laws of the Council. Their suggested new set of by-laws is attached to this note. Proper procedure would include approval of these by this Executive Committee forwarding them to the membership of the Council a number of days before the next annual meeting; and in all probability, appointing a committee of that membership to report at that annual meeting and voting on any changes at the Annual Meeting. As such, the recommendations of the By-laws Committee must be acted upon by this Committee no later than the middle of September.

Amend ARTICLE 2, Section 2 of the bylaws, the first two sentences to read as follows:

For purposes of electing the nominating committee, the secretary-treasurer shall send to the members of the Council, on or about February 1st, the names of 14 members of the Council, chosen by the Executive Committee, with a request that each member indicate the seven persons he thinks best qualified to serve as members of the nominating committee. 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.

(The remainder of ARTICLE 2 would stand as it is now written.)

ARTICLE 7.

The Constituent Societies of the Council of Academic Societies shall be grouped into panels of societies with similar interests and functions, in order to facilitate communication on matters of common interest, both within and among the various panels.

The list of panels shall include the following and may be amended as the need arises:

1. PANEL OF PROFESSORIAL SOCIETIES: shall include societies consisting exclusively of departmental chairmen or teachers in a field of medical education.

2. PANEL OF PROFESSIONAL SOCIETIES: shall include societies with membership defined by particular fields of research or medical practice such as the American Association of Anatomists or the American Neurological Association.

3. PANEL OF INSTITUTIONAL SOCIETIES: consisting of societies with membership drawn from a single institution, such as the faculty or student body of a medical school.

Members of the Executive Committee of the Council of Academic Societies, exclusive of officers, shall be selected in such a way as to provide equitable representation from each panel.

ARTICLE 8.

Officers and members of the executive committees or councils of constituent societies shall be considered members, ex-officio, of the Council of Academic Societies and shall receive all information concerning meetings and activities of the Council of Academic Societies that is distributed to its regular members. However, no ex-officio member may vote or hold office in the Council of Academic Societies unless he also serves as officially designated representative of a constituent society to the Council of Academic Societies.

# 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.

CMS:es
#6000- 16

TO: Executive Committee

FROM: Staff

RE: Election of New Societies for Membership in the Council

There has been no lack of interest in new societies joining the Council. Attached to this memorandum is a complete summary of all the societies which have applied for membership with a note on the status of their applications. Also attached to refresh your memory is a list of the societies which are members.

Seven societies have complete applications which are ready for action by the Council. These are appended and in each instance supplementary data on the Society is available.

Our procedure for election calls for approval by the Executive Committee, election by the Council of Academic Societies, approval by the Executive Council and finally election by the Assembly. Last year, an effort was made to get the Executive Council to act before the Council of Academic Societies had acted. They refused to do so. This particular sequence makes selection very ponderous and consumes a great deal of time. It is suggested that this Executive Committee recommend to the Executive Council and to the membership of the Council of Academic Societies that the orders of these procedures be changed to: approval by the Executive Committee, Council of Academic Societies; approval by the Executive Council, AAMC; election by membership, CAS; ratification by membership of the Assembly.

# COMPLETED APPLICATIONS TO BE ACTED UPON

| Name of Organization | Status |
|---|---|
| American Academy of Ophthalmology and Otolaryngology | Completed application 3/20/70 |
| American College of Physicians | Completed application 12/69<br>Membership approved in principle<br>CAS Executive Committee, CAS Membership, AAMC Executive Council |
| American Academy of Pediatrics | Completed application 3/25/70<br>Same status as American College of Physicians |
| American College of Surgeons | Completed application 12/69<br>Same status as American College of Physicians |
| Plastic Surgery Research Council | Completed application 3/2/70<br>One plastic surgery society already a member. Inquiries from others |
| Society for Pediatric Research | Completed application 2/70<br>Other research societies are members |
| American Academy of Allergy | Completed application 5/70 |

## PARTIALLY COMPLETED APPLICATIONS

| Name of Organization | Status |
|---|---|
| Association of Medical School Microbiologists | Organization still in formative stages |

## ELECTED BUT RESIGNED

| Name of Organization | Status |
|---|---|
| Academy of Microbiology | Elected 5/3/67. Resigned 6/3/69. Programs of CAS, Programs not relevant |
| American Gynecological Society | Elected 5/67. Resigned 6/5/68. Education not a primary concern of its members. |
| Association of University Cardiologists | Elected 5/67. Election not accepted 2/68. Budget too small to pay dues. |

# INQUIRIES

## ENCOURAGED - NO COMPLETE APPLICATION

| Name of Organization | Status |
|---|---|
| American College of Cardiology | Inquiry 4/9/70. Invited to complete application |
| Endocrine Society | Inquiry 11/69. Further follow up necessary |
| American Society for Pharmacology and Experimental Therapeutics | Extensive correspondence 1967-69. Resolved by formation of Chairman's Society -elected to CAS in November, 1969. |
| American College of Obstetrics and Gynecology | Application discouraged in 1968 but on 3/12/70 invited to submit application...No further response. |
| American Psychosomatic Society | Inquiry 12/69. No further follow up. |
| Orthopsychiatric Association | Inquiry 12/69. No further follow up. |
| Central Society for Clinical Research | Inquiry 2/70. Encouraged |
| American Association for Immunologists | Inquiries 1967-68. Encouraged |
| American Society for Internal Medicine | Inquiry 7/69. Discouraged pending disposal of application of the American College of Surgeons |
| American Psychiatric Association | Inquiry 12/69. No follow up. |
| American Association of History of Medicine | Inquiry 5/4/70. No further follow up. |

INQUIRIES

ENCOURAGED - NO COMPLETE APPLICATION

| Name of Organization | Status |
|---|---|
| American Society for Clinical Investigation | Inquiry May 1970. |

INQUIRIES

DISCOURAGED - INCOMPLETE APPLICATIONS

| Name of Organization | Status |
|---|---|
| Association for Research in Opthalmology, Inc. | Inquiry 10/68. Discouraged - Program only research with no education. |
| American Academy of Neurology | Inquiry 12/69. A "college". Four other "neurological" organizations already belong. |
| American Academy of Psychoanalysis | Inquiry 11/68. No answer to follow up letter. |
| American College of Psychiatrists | Inquiry 5/67. No answer to follow up letter. |
| Coordinators of Cancer Teaching | Inquiry 11/66. Discouraged. |
| Council on Resident Education in Obstetrics and Gynecology | Inquiry 11/68. Discouraged. |
| American Association for Cancer Education | Inquiry 12/69. Discouraged. |
| American Society of Psychologists in Medical Education | Inquiry 1967. Discouraged. |

COMPLETED APPLICATIONS - NOT ACCEPTED

PREVIOUSLY ACTED ON BY THE EXECUTIVE COMMITTEE

| Name of Organization | Status or Previous Action |
|---|---|
| Society of Teachers of Family Medicine | Application deferred 11/69 but encouraged to reapply. |
| American Association for Thoracic Surgery | Application accepted by CAS Executive Committee and CAS membership on 11/69, but on subsequent review by Executive Committee recommendation for election withdrawn. Current status uncertain. |
| American Academy of Physical Medicine and Rehabilitation | 11/69 refused. Another physical medicine society elected at that time. This is a "college." |
| American Academy of Dermatology | 11/68 refused. Other dermatological societies members. This is a "college." |
| American Gastroenterological Association | November 1969 accepted by Executive Committee for membership. On subsequent review by the Executive Committee recommendation for election withdrawn. Current status uncertain. |
| American Society of Plastic and Reconstruction Surgeons, Inc. | November 1968. Not accepted. Other plastic surgery societies in. A "college." |
| Association for Hospital Medical Education | Aggressive drive for membership in 69-70. Application refused. Liaison through COTH in discussion. |

# COUNCIL OF ACADEMIC SOCIETIES

1. Academic Clinical Laboratory Physicians and Scientists
2. American Association of Anatomists
3. American Association of Chairmen of Departments of Psychiatry
4. American Association of Neurological Surgeons
5. American Association of Neuropathologists
6. American Association of Pathologists and Bacteriologists
7. American Association of Plastic Surgeons
8. American Association of University Professors of Pathology
9. American Neurological Association
10. American Pediatric Society
11. American Physiological Society
12. American Society of Biological Chemists, Inc.
13. American Surgical Association
14. Association for Medical School Pharmacology
15. Association of Academic Physiatrists
16. Association of American Physicians
17. Association of Anatomy Chairmen
18. Association of Chairmen of Departments of Physiology
19. Association of Medical School Pediatric Department Chairmen, Inc.
20. Association of Professors of Dermatology
21. Association of Professors of Gynecology and Obstetrics
22. Association of Professors of Medicine
23. Association of Teachers of Preventive Medicine
24. Association of University Anesthetists
25. Association of University Professors of Neurology
26. Association of University Professors of Ophthalmology
27. Association of University Radiologists
28. Joint Committee on Orthopaedic Research and Education Seminars

29. Society of Academic Anesthesia Chairmen, Inc.

30. Society of Chairmen of Academic Radiology Departments

31. Society of Surgical Chairmen

32. Society of University Otolaryngologists

33. Society of University Surgeons

34. Society of University Urologists

1. Name of Society

   American Academy of Ophthalmology and Otolaryngology

2. Purpose

   To promote and advance the science and art of medicine appertaining to the eye, ear, nose, and throat and to encourage the study of the relationships of these specialties to surgery, general medicine and hygiene.

3. Membership

   The membership consists of Active Fellows, Life Fellows, Inactive Fellows, Associate Fellows, and Honorary Fellows. Members must be in good standing with his or her local and national medical society and shall be certified and approved by a national examining and certifying specialty Board acceptable to the Council.

4. Number of Members

   9,253

5. Constitution and Bylaws available

6. Minutes of the Business Meeting held on 10/16/69 available

7. Organized

   1896 under the name of the Western Ophthalmological and Otolaryngological Society. In 1902 the name was changed to the present one.

8. Recommendation -

1. Name of Society

American College of Physicians

2. Purpose

To establish an organization composed of qualified internists of high standing who shall meet from time to time for the purpose of considering and discussing medical and scientific topics, and who through their organization shall attempt to accomplish the further purposes of: a) maintaining and advancing the highest psssible standards in medical education, medical practice and research, b) preserving the history and perpetuating the best traditions of medicine and medical ethics, and c) maintaining both the dignity of Internal Medicine and the efficiency of its function in relation to public welfare.

3. Membership

The membership shall consist of Masters, Fellows, Honorary Fellows, Corresponding Fellows, Associate Members, Affiliate Members and Candidate Members. Members must be members of the medical profession engaged as practitioners, teachers or research workers in Internal Medicine or in an allied specialty. Every candidate must be proposed and seconded by a Master or Fellow who is not an Officer, Regent, or Governor of the College and endorsed by the Governor of his jurisdiction. The Committee on Creditentials makes the decision as to whether the candidate be recommended to the Board of Regents for election to Association Membership or Fellowship.

4. Number of Members

15,000

5. Constitution and Bylaws available

6. Minutes for the Board of Regents' Meeting held on 4/20/69 and 4/25/69 are available

7. Organized

May 11, 1915

8. Recommendation -

1. Name of Society

American Academy of Pediatrics

2. Purpose

To establish standards in appropriate areas, to perpetuate pediatric history and the best traditions of pediatric practice and ethics, and to maintain the dignity and efficiency of pediatric practice in its relation to public welfare.

3. Membership

Members, known as Fellows, must have a minimum of 5 years' specialized study and/or practice in pediatrics, provide evidence of high ethical and professional standing and clinical experience as determined by Fellows in the district, and have adequate training and continuing activity in the field of pediatrics. There are also provisions for Specialty, Affiliate, Honorary Associate, Honorary, Corresponding, Emeritus Fellows, and Candidate Members.

4. Number of Members

11,000

5. Constitution and Bylaws are available

6. Minutes of the Annual Business Meeting held on 10/23/68 available
38th Annual Meeting Program held on 10/18-23/69 available

7. Organized

1931

8. Recommendation -

1. Name of Society

American College of Surgeons

2. Purpose

To maintain an association of surgeons, not for pecuniary profit, but for the benefit of humanity by advancing the science of surgery and the ethical and competent practice of its art.

3. Membership

Members are designated as "Fellows." Any legalized practitioner of medicine may apply for Fellowship, or a request may be made, by any Fellow of the College or other member of the medical profession, that application forms be sent to a surgeon who, in his opinion, is qualified for Fellowship. The Board of Regents takes final action on all candidates elected to Fellowship.

4. Number of Members

30,000 with Fellows in 88 countries

5. Constitution not available
Bylaws are available

6. Program for the 55th Annual Clinical Congress held on 10/6-10/69 is available. Minutes for the Meeting of the Board of Regents held on 10/3,4,5,10/69 are also available.

7. Organized

1913

8. Recommendation -

1. Name of Society

Plastic Surgery Research Council

2. Purpose

To stimulate fundamental research, curriculum and methods of teaching in Plastic Surgery.

3. Membership

Membership is restricted to those who are engaged in fundamental research applicable to plastic surgery, and who have published work of merit. There are three categories of Members: Active(those qualified plastic surgeons under the age of 45), Senior(Active members over the age of 45), and Associate(individuals whose contributions make their inclusion in the Council desirable).

4. Number of Members

79

5. Constitution and Bylaws available

6. Minutes from the 14th Annual Business Meeting held on 4/25/69 available

7. Organized

1955

8. Recommendation -

1. Name of Society

Society for Pediatric Research

2. Purpose

To foster pediatric investigation and to provide an opportunity for younger investigators to present their work for discussion and criticism at a national meeting.

3. Membership

Nominees for membership should have completed their formal training and have demonstrated consistent, independent research during his training period. He should have also published in journals with a review process and the Council must evaluate the nominee's research. Nominees must be under the age of 45.

4. Number of Members

383 Active, and 345 Emeritus

5. Consitution and Bylaws available

6. Program and Minutes for the Annual Business Meeting held on May, 1969 available

7. Organized

1929

8. Recommendation -

1. Name of Society

American Academy of Allergy

2. Purpose

To advance the knowledge and practice of Allergy, by discussion at meetings, by fostering the education of students and the public, by encouraging union and cooperation among those engaged in this field, and by promoting and stimulating research and study in Allergy.

3. Membership

The membership will consist of Fellows, Emeritus Fellows, Honorary Fellows, Corresponding Fellows, Members, Emeritus Members, Affiliate Members and Corresponding Members. Fellows may be unlimited in number and may be elected from the ranks of Members. Candidates for Membership shall be doctors of medicine or equivalent foreign degrees with a demonstrated interest in Allergy, recommended by the Executive Committee. Affiliate Members shall consist of persons engaged in a technical or administrtive capacity in allergy or related fields, but who do not necessarily posses a graduate degree.

4. Number of Members

1,869

5. Constitution and Bylaws available

6. Minutes and program of the Annual Meeting held on 2/17/70 available

7. Organized

December 4, 1943 the American Association for the Study of Allergy and the Society for the Study of Asthma and Allied Conditions merged

8. Recommendation -

1. Name of Society

   The American College of Obstetricians and Gynecologists

2. Purpose

   To foster and stimulate interest in obstetrics and gynecology and in all aspects of the work for the welfare of women which properly come within the scope of obstetrics and gynecology.

3. Membership

   Members, known as Fellows, shall have continuous limitation of his training and/or professional activities to obstetrics and gynecology for the five years immediately prior to the date of his application. He must also have demonstration of evidence of high ethical and professional standing, including clinical ability and experience as determined by the Fellows in his District and successful completion of an examination in obstetrics and gynecology which is satisfactory to the Executive Board.

4. Number of Members

   9,243 full Fellows in the College and 12,855 Fellows in all categories

5. Bylaws available

6. Minutes of the Annual Business Meeting - April 30, 1969 - available

7. Organized

   1951

8. Recommendations -

1. Name of Society

American Society for Clinical Investigation, Inc.

2. Purpose

This society is organized and operated exclusively for educational and scientific purposes and for no other purpose.. The objectives are: the advancement of medical science; the cultivation of clinical research by the methods of the natural sciences; the correlation of science with the art of medical practice; the encouragment of scientific investigation by the medical practitioner; the diffusion of a scientific spirit among its members.

3. Membership

Membership is open to any physician residing in the United States or Canada who is less than 45 years old, has accomplished meritorious original investigations in the clinical or allied sciences of medicine and enjoys an unimpeachable moral standing in the medical profession. A member may become an emeritus member (a) at any time upon his own request after five years of active membership or (b) automatically at the conclusion of the annual meeting following the calendar year in which the member has his forty-fifth birthday.

4. Number of Members

452

5. Bylaws are available

6. Program and Minutes of the 62nd Annual Meeting held on May 4, 1970 are available

7. Organized

1902

8. Recommendations -

TO: Executive Committee, CAS

FROM: Staff

RE: Dues

Currently, the dues of the Council of Academic Societies are $100 per society per year. This is clearly inadequate. In light of increasing responsibilities and in light of the actions taken in connection with the Welt Committee, it is apparent that an increased dues are necessary.

Therefore, it is suggested that the Council be divided into panels of societies, professional and professorial, and in addition:

1. Dues of professorial societies be set at $10.00 per member, not to be less than $500 per year and not to exceed $1,000 per year.

2. That dues for professional societies be set at $1.00 per member, not to be less than $500 per year, and not to exceed $2,000 per year.

With the societies now members of the Council, this would result in an income of $31,500 per year.

If one takes into account committee work, staff time, and travel, the expenditures for the Council of Academic Societies' programs are approximately twice this.

| AAMC CODE | COUNCIL OF ACADEMIC SOCIETIES PROFESSORIAL SOCIETIES | # OF MEMBERS |
|---|---|---|
| 1 | Academic Clinical Laboratory Physicians and Scientists | 75 |
| 3 | American Association of Chairmen of Departments of Psychiatry | 96 |
| 8 | American Association of University Professors of Pathology | 100 |
| 14 | Association for Medical School Pharmacology | 90 |
| 15 | Association of Academic Physiatrists | 176 |
| 17 | Association of Anatomy Chairmen | 90 |
| 18 | Association of Chairmen of Departments of Physiology | 91 |
| 19 | Association of Medical School Pediatric Department Chairmen, Inc. | 115 |
| 20 | Association of Professors of Dermatology | 120 |
| 21 | Association of Professors of Gynecology & Obstetrics | 250 |
| 22 | Association of Professors of Medicine | 81 |
| 23 | Association of Teachers of Preventive Medicine | 400 |
| 25 | Association of University Professors of Neurology | 67 |
| 26 | Association of University Professors of Ophthalmology | 81 |
| 28 | Joint Committee on Orthopaedic Research & Education Seminars | 230 |
| 29 | Society of Academic Anesthesia Chairmen, Inc. | 135 |
| 30 | Society of Chairmen of Academic Radiology Departments | 60 |
| 31 | Society of Surgical Chairman | 86 |
| 32 | Society of University Otolaryngologists | 78 |
| 34 | Society of University Urologists | 60 |

| AAMC CODE | PROFESSIONAL SOCIETIES | # OF MEMBERS |
|---|---|---|
| 2 | American Association of Anatomists | 2039 |
| 4 | American Association of Neurological Surgeons | 1134 |
| 5 | American Association of Neuropathologists | 351 |
| 6 | American Association of Pathologists and Bacteriologists | 1025 |
| 7 | American Association of Plastic Surgeons | 150 |
| 9 | American Neurological Association | 411 |
| 10 | American Pediatric Society | 254 |
| 11 | American Physiological Society | 3006 |
| 12 | American Society of Biological Chemists, Inc. | 2307 |
| 13 | American Surgical Association | 290 |
| 16 | Association of American Physicians | 250 |
| 24 | Association of University Anesthetists | 108 |
| 27 | Association of University Radiologists | 215 |
| 33 | Society of University Surgeons | 500 |

TO: Executive Committee, CAS

FROM: Staff

RE: Involvement of More Individuals in Individual Membership

One of the perplexing and persistent problems facing the Council of Academic Societies has to do with the fact that the number of individuals involved in its affairs remains very small, about 75 at the most. For a national organization, this is inadequate. Therefore, some method must be found to involve more members in the affairs of the Council. A number of mechanisms are possible. It has been often stated that a regional structure for the Council is not likely to succeed. Actually, on three or four matters it is now considering, the interest of faculty members is sufficiently great that some regional meeting pattern, particularly if an action program were included, would be very useful. These include reactions to and input into the National Library of Medicine, especially if some money becomes available there, certainly a reaction to and involvement in any positive program or recommendations elaborated by the Biomedical Research Committee, and possibly reaction to and actions on the recommendations of the Physician's Assistants Committee.

If appropriate people were tapped to meet at the time of national meetings to look at these problems or even to meet with regional meetings of the Council of Deans, interest in the Council could spread.

Finally, the mailing list is too small. It has been suggested that the mailing be expanded to include all the officers and the members of all the Executive Committees of all of the societies of the Council. Furthermore, if all of these men were considered members of the Council and were considered eligible for officership in staff positions, the result would be a much broader group of people with whom we are working. This would involve a good deal of staff work in keeping up with the officers of the various societies, but this is not an overwhelming task; that it would also result in a mailing list of somewhere between 500 and 1,000, which is considerably more than our current 75 to 100 but considerably less than the 12 to 20,000 which the membership of the member societies probably now totals. Some definite policies should be laid down for the staff. It is recommended that:

1. Steps be taken to broaden the membership of the Council of Academic Societies to include all the officers and all the members of the Executive or Senior Steering Committees of every member society.

2. That a mailing of these individuals be put together and that appropriate matters pertaining to the business of the Council be sent to these individuals at regular intervals.

3. That a news letter be initiated and mailed to the membership of the Council at least quarterly.

4. That, on a trial basis, at least three Deans Regional Meetings and a group from the Council of Academic Societies be convened to act on one or two or perhaps all of the following matters:

a) Recommendations coming from Biomedical Research Policy Committee.

b) Recommendations of Physician's Assistants Committee.

c) Recommendations being formulated by the National Library of Medicine.

TO: Executive Committee, CAS

FROM: Staff

RE: 1970 Annual Program

The Annual Program of the Council for 1970 is as follows:

Friday afternoon, October 30 -- Education of Manpower for Primary Health Care

1. What is Sufficient Health Manpower? Mr. Walter McNerny, President of Blue Cross/Blue Shield

2. The Needs of the General Practitioner in an Urban Setting. Dr. James Ainsworth, Houston, Texas

3. The Needs of the Internist in an Urban, Non-University Setting. Dr. Donald Saunders, Columbia, South Carolina

4. The Needs of a Large Pre-Paid Health Plan. Dr. Eugene Vayda, McMaster University

5. The Needs of Federally Sponsored Community Health Centers. Dr. Joyce Sarhoff, Mile Square Project, Chicago, Ill.

6. The Position of the Medical Schools. Dr. James V. Warren, Professor of Medicine, Ohio State University

Saturday afternoon, October 31

1. Report of Committee on Biomedical Research and Recommendations

2. Report of National Library of Medicine Committee and Recommendations

3. Annual Business Meeting of the Council - suggested agenda will be put together during the fall.

TO: Executive Committee, CAS

FROM: Staff

RE: Committee Reports

1. Activities of Biomedical Research Policy Committee -- Drs. Daniel C. Tosteson and James V. Warren have been active with this committee and will report.

2. Physician's Assistants Committee -- Since our last meeting, the following recommendations concerning the report of Physician's Assistants Committee were adopted by the Executive Council*. The Liaison Committee on Medical Education is being sent these. It is probable that at its next meeting, which is now scheduled for early July, it will take affirmative action, and the joint subcommittee mechanism recommended in the above will be activated.

3. National Library of Medicine Committee -- The National Library of Medicine Steering Committee is to meet on June 17. Various subcommittees have met in the interval, and an oral report will be made.

4. Graduate Medical Education Committee -- This committee has not been active due to the delinquencies of the staff. Attached is a version of the position paper which should be edited and circulated as soon as there is staff backup available to allow this committee to be effective.**

* Attachment H-1
** Attachment H-2

Excerpt

AAMC Executive Council Meeting

May 7, 1970

Report on Physician's Assistants Training Program:

The report has been received by the CAS Executive Committee but has not been approved. At its last meeting, the LCME voted to invite representatives of the AMA Council on Medical Education, AMA Council on Health Manpower, and the AAMC to form another task force charged with taking the recommendations of this report the next step: sufficient clarification for their presentation to the AMA House of Delegates and to the AAMC Assembly.

The AAMC Executive Committee felt that it would be premature for the Executive Council to act on this report before it had been discussed by COD and COTH; in view of "timing" problems, however, it was felt that AAMC representatives should be appointed now to meet with AMA representatives.

ACTION: On motion, seconded and carried, the Executive Council accepted the report of the Task Force as information, and directed that individuals be appointed to meet with representatives of the AMA Councils.

TO: Executive Committee of the CAS

FROM: Staff

RE: Report on Physician's Assistants Training Program

The report has been received by the Executive Council of the Association. It was recommended that:

1. The attached report be accepted as information.

2. Individuals be appointed to meet with representatives of the AMA Councils;

3. The Executive Council support the position that the accreditation of university-connected programs leading to certification of Type A physician's assistants education programs be undertaken on a joint basis by AAMC and AMA through the Liaison Committee mechanism.

4. The Health Services Advisory Committee be asked to address itself to the problems related to the institutional employment of such personnel.

5. These actions be interpreted as formal endorsement by this Association that the training of Type A physician's assistants is a proper function of academic medical centers.

6. The time tables of the group meeting with the AMA and of the Health Services Advisory Committee be set up to permit formulation of recommendations for adoption by the Assembly in [illegible]

# CORPORATE RESPONSIBLILITY FOR GRADUATE MEDICAL EDUCATION

In the context of this paper corporate responsibility for graduate medical education is defined as the assumption by the university and its collective faculties of the classic responsibility and authority of a university for all its students and programs in medical education. This implies that the faculty of the medical school will collectively assume the responibility for the education of clinical graduate students (interns and residents) in all departments 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 departmental 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 and its faculties.
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, content and progress, through training and determination of elegibility for admission to the specialty board examinations are now determined largely by individual Boards. Such Boards are characteristically private, not-for-profit organizations, usually answerable only to themselves and with self-perpetuating directorships. They have no particular responsibilities to universities or hospitals.

All internships are approved by the Internship Committee of the Council on Medical Education of the A.M.A. All residency programs are accredited by the Residency Review Committees, with the exception of Pathology. The American Board of Pathology directly examines and accredits its residency training programs. The Residency Review Committees are all made up of appointees of the specialty section of the A.M.A. and the appropriate Board. Many of the Residency Review Committees, in addition to these two appointing agencies, have appointees from the appropriate College or Academy. The Residency Review Committees are autonomous and do not have to report back to the parent organizations for a verification of their decisions. The graduate education section of the Council on Medical Education of the A.M.A. provides secretarial assistance and administrative support for the operation of all Residency Review Committees. The concern of the Council on Medical Education for all facets of medical education is a matter of historical record. In the area of graduate education, however, the Council has essentially no authority over either the Boards or the Residency Review Committees since both function

independently and autonomously. It should be noted that the A.M.A. 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 practicing physicians whose direct contact with education has either ended or become a small part of their professional activity.

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 noe, 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 should have significant influence on the process of graduate medical education. It has very real authority, through its influence over hospital policies and the appointments of service chiefs, but it may or may not have real operational responsibility.

(operational responsibility.) Its faculty as a group ~~has~~ may have 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 interrelation 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.