AGENDA
COUNCIL OF ACADEMIC SOCIETIES
EXECUTIVE COMMITTEE
February 11, 1971
5:30 - 11:00 p.m.
PDR 4
Palmer House
Chicago, Illinois

	TAB
1. Consideration of minutes, December 15, 1970 meeting	A
ACTION ITEMS	
2. Report, Subcommittee on CAS Future Structure & Objectives	B
3. Planning Future Meetings	
CAS Membership, February 12, 9:00 a.m. - 5:00 p.m., Chicago	C
AAMC Assembly, February 13, 2:00 p.m. - 5:00 p.m., Chicago	
CAS Annual Meeting, October 29, 2:00 p.m. - 5:00 p.m., Washington	D
4. Report, Committee on Graduate Medical Education	E
INFORMATION ITEMS	
5. Report, AAMC Executive Council December 16 actions on CAS recommendations:	
Societies recommended for Membership	
Motion regarding Biomedical Science Office	
Motion regarding Training Primary Physicians	
Motion regarding Physicians' Assistants	
6. Report, Nominating Committee	F
7. Report, Committee on Biomedical Research Policy	
8. Report, Committee on Biomedical Communications Network	
9. AAMC position on National Health Insurance	G
10. AAMC Faculty Salary Study	H
11. Next meeting, April 15, 9:00 a.m. - 3:00 p.m. Cosmos Club, Washington, D. C.	
12. Adjournment	

[Tab A]

MINUTES
EXECUTIVE COMMITTEE
COUNCIL OF ACADEMIC SOCIETIES
December 15, 1970

Cosmos Club
Washington, D.C.

Present:	Committee Members	Staff
	James V. Warren, Chairman (Presiding)	John A. D. Cooper
	Sam L. Clark, Jr.	Mary H. Littlemeyer
	Ronald W. Estabrook	Joseph S. Murtaugh
	Ernst Knobil	August G. Swanson
	William B. Weil, Jr.	Marjorie P. Wilson

Absent: Committee Members

Patrick J. Fitzgerald
Charles Gregory
* Thomas D. Kinney
William P. Longmire, Jr.
* Jonathan E. Rhoads
Louis G. Welt

* Ex Officio

The Committee convened with luncheon at noon.

I. Adoption of Minutes

The minutes of the CAS Executive Committee held on October 29 and October 31, 1970 were adopted as circulated.

The minutes of the 1970 CAS Annual Meeting held October 30-31, 1970 were adopted as circulated to the CAS Membership on November 20, 1970.

II. Director, Department of Academic Affairs

Present in the meeting was Dr. August G. Swanson, newly appointed Director of the Department of Academic Affairs. Dr. Swanson will assume this office full time on February 1, 1971.

III. Action Items for AAMC Executive Council

Next reviewed were the four recommendations the CAS Membership adopted in its Annual Business Meeting held on October 31, 1970. These

recommendations, which follow, were to be presented by the Chairman at the December 16 AAMC Executive Council meeting:

1. That the Association of American Medical Colleges establish an Office of Biomedical Research within the Department of Academic Affairs. The purpose of this Office would be to attract a full-time staff to implement a biomedical research policy and to facilitate communication between the CAS and its constituent societies in matters of biomedical research.

2. That the Association of American Medical Colleges appoint a committee to study the establishment of definitions and standards for various assistants to physicians, and an accrediting mechanism for programs producing such individuals, and that such action be taken, if necessary, without participation of the AMA.

3. That the Association of American Medical Colleges establish a group for the study of the problems in the education of physicians for primary health care.

4. That the election of the following societies which have been approved by the Council of Academic Societies be recommended to the Assembly at its February, 1971 meeting:

    1. American Academy of Allergy
    2. American Academy of Ophthalmology and Otolaryngology
    3. American Academy of Pediatrics
    4. American Association for Thoracic Surgery
    5. American College of Obstetricians and Gynecologists
    6. American College of Physicians
    7. American College of Surgeons
    8. American Gastroenterological Association
    9. American Society for Clinical Investigation, Inc.
    10. Association for Academic Surgery
    11. The Endocrine Society
    12. Plastic Surgery Research Council
    13. Society for Pediatric Research

Regarding the first resolution, it was emphasized that the intent of the motion was not to dictate internal organizational structure to the AAMC.

IV. Nominating Committee

The newly adopted Bylaws call for distribution by the Secretary on or before December 1, a list of 14 CAS members selected by the CAS Executive Committee from which seven shall be selected to comprise the Nominating Committee. This ballot went out on December 2 and returns were to be postmarked no later than December 17. At the time of the meeting, about 25 (out of a possible 63) returns were in.

V. Committee on Biomedical Research Policy

Dr. Louis G. Welt, newly elected member of the CAS Executive Committee and Chairman of the CAS Committee on Biomedical Research Policy, was unable to attend the first meeting of the Executive Committee. In his absence, Dr. Warren, Dr. Cooper, and Mr. Murtaugh summarized the current and projected activities in this area.

1. The first Interim Report of the Committee was presented by Dr. Welt at the CAS Annual Meeting on October 31. Dr. Welt subsequently made the text, a 22-page document, available to Drug Research Reports (The "Blue Sheet") where it was printed in toto.

   Minutes of the CAS Annual Meeting were distributed to the full CAS membership, which consists of officially designated representatives of the 34 constituent societies, plus ex officio, all their officers and executive committees, councils, or boards. This distribution totals just under 300. In the minutes, this presentation was briefly referenced and availability of the full text upon request was announced. The full text was sent automatically to all CAS designated members (63 men), as well as to the Committee on Biomedical Research Policy, and to the CAS Executive Committee not represented in the other two groups.

2. The Final Interim Report is currently being edited and will contain data on the economic consequences of health and biomedical research. This is expected to be completed in early February, 1971.

3. An editorial for Science is being prepared by Dr. Welt, who will circulate it for critique to the Biomedical Research Policy Committee and to key AAMC staff.

The gap between expectations and results, in particular vis-a-vis financial contributions by the constituent organizations, was discussed. Dr. Estabrook said for his purposes an official resolution, six sentences or so, coming from this body would contain sufficient weight for effective use by his organization in influencing Congress. Dr. Weil said that the members had wanted feedback on the activities of other organizations with regard to the Federal government.

For the information of the Executive Committee a confidential report of the special contributions received to date to support the expenses of the Committee on Biomedical Research Policy is attached to these minutes. As will be noted, the total amounts to $17,850.

The Committee on Biomedical Research Policy, a 15-man committee, representing every major discipline and specialty, has met since its appointment five times: February 5 in Chicago; April 9-10, May 6-7, and July 24 in Washington; and October 30 in Los Angeles. In addition, AAMC sponsored a full-day meeting, which was attended by between 125-150 representatives of national organizations, in Chicago. Dr. Cooper reported that an effort analysis indicated that the AAMC has expended close to $175,000 in programs in support of biomedical research and research training.

Decisions reached were:

1. That it would be appropriate to talk to Dr. Welt in this regard;

2. That it would be appropriate to invite representatives of the Biomedical Research Policy Committee to meet with the CAS Executive Committee in February, 1971;

3. That it would be appropriate to try to develop a statement as described by Dr. Estabrook.

VI. Physicians' Assistants

According to Dr. Marjorie P. Wilson, the Liaison Committee on Medical Education has appointed a Committee whose focus will be on this issue. Dr. Edmund Pellegrino is Chairman, and AAMC representatives are Mr. H. Robert Cathcart, Dr. E. Harvey Estes, and Dr. Thomas D. Kinney.

Dr. Weil was critical of the absence of representation from the allied health professions. Dr. Wilson noted that nursing had no representation. Dr. Weil further observed that it is possible that PA's will be trained for jobs that do not exist or else for jobs that have to be created for roles that are inappropriate to the delivery of health care.

VII. CAS: Future Structure & Objectives

The Committee considered at length the following motion (the "Wedgwood" motion) adopted by the CAS Membership on October 31, 1970:

> That the Executive Committee bring to the Council at the next meeting more specific recommendations for eligibility criteria for component societies, and for representation of the CAS at the Assembly, to meet the stated objectives of the CAS, namely to serve as a forum and expanded medium for communication between the AAMC and the faculties of schools of medicine, such recommendations, including possible totally alternative options, to be formulated either by the Executive Committee, or by an ad hoc committee composed of voting members containing a reasonable balance between the clinical and preclinical disciplines.

Dr. Warren was charged to appoint a Subcommittee, comprised of those who sit on both the CAS Executive Committee and on the AAMC Executive Council, namely, in addition to Dr. Warren, Dr. Clark, Dr. Kinney, and Dr. Rhoads, to develop options for the February agenda.

Named by Dr. Weil as the most obvious possibilities in response to a part of the motion, were:

1. To continue the CAS as is, growing and expanding; or
2. To limit the CAS in some way; or
3. To abolish the CAS and establish a Council of Faculty.

It was emphasized that any plans for consideration by the CAS in this matter would likely be an exercise in futility unless they were coordinated with the overall design for the AAMC's changing structure.

VIII. Annual Meeting

Dr. Cooper asked for ideas to modify the Annual Meeting format so as to reduce the overall span of time individuals are now required to spend in order to attend those sessions in which they have special interest. One suggestion received had been that the AAMC Councils limit their program to one-half day.

Many expressed great interest in returning to the Institute concept and design.

IX. February CAS Meeting

The CAS Membership is scheduled to hold an all-day meeting on February 12 (Palmer House).

In addition to the several suggestions as recorded in the October 29 minutes, ideas contributed were:

- CAS Structure and Function
- Role of Faculty
- The Crisis in Basic Sciences (or Anxiety Syndrome of Basic Sciences)
  -- Penrod; Meredith Wilson; Pellegrino; Emanuel Suter; Don Seldon (highly favored); someone from Brown or Mt. Sinai; Grobstein, U.C.S.D.; or Tom Morgan, Washington-Seattle.
- Departments of Family Practice--What are the programs doing?
- Practical Politics - Mr. Lee Goldman (AAMC Staff)
- Carnegie Commission, summary by Clark Kerr, followed by debate
- Role of the Institute on Medicine in relation to academic medicine, by Phil Handler

Before making definitive plans, the Chairman will consult Dr. Ruhe so that there is no overlap between the CAS program and that of the AMA Congress on Medical Education.

X. Next Meetings

CAS Executive Committee
(Thurs.) February 11, 1971
8 pm - 11 pm
Palmer House
Chicago, Illinois

CAS Membership
(Fri.) February 12, 1971
9 am - 5 pm
Palmer House
Chicago, Illinois

AAMC Assembly
(Sat.) February 13, 1971
2 pm - 5 pm

XI. Future Meetings

The following meeting dates were tentatively established, all to be held in Washington:

April 15, 1971 -- 9 am - 3 pm
June 24, 1971 -- 9 am - 3 pm
September 16, 1971 -- 9 am - 3 pm

These dates were selected to coincide with those of the AAMC Executive Council. The CAS Representatives to the Executive Council will, therefore, be able to report to the Executive Council at the meetings which follow. This planning will also reduce travel time for these representatives.

XII. Adjournment

The meeting was adjourned at 5:00 pm.

Att. 1

Revised 12/21/70

COUNCIL OF ACADEMIC SOCIETIES
FUNDING FOR COMMITTEE ON BIOMEDICAL RESEARCH POLICY

Society	Number of Members	Rec'd.	Pledged
1. Academic Clinical Laboratory Physicians and Scientists	223	$ 750	
2. American Association of Anatomists	2157	2039	
3. American Association of Chairmen of Departments of Psychiatry	94	960	
4. American Association of Neurological Surgeons*	1443		
5. American Association of Neuropathologists	351		est. 351
6. American Association of Pathologists and Bacteriologists*	1094		
7. American Association of Plastic Surgeons	100		135
8. American Association of Chairmen of Medical School Departments of Pathology, Inc.*	110		
9. American Neurological Association*	411		
0. American Pediatric Society	254		254
1. American Physiological Society	3286	3286	
2. American Society of Biological Chemists, Inc.	2519		2400
3. American Surgical Association*	290		
4. Association for Medical School Pharmacology*	117		
5. Association of Academic Physiatrists	176	176	
6. Association of American Physicians	250	2965	
7. Association of Anatomy Chairmen	105	660	
8. Association of Chairmen of Departments of Physiology	103	900	
9. Association of Medical School Pediatric Department Chairmen, Inc.	118		est. 1000
0. Association of Professors of Dermatology	120		est. 250
1. Association of Professors of Gynecology and Obstetrics	250		
2. Association of Professors of Medicine	100	1000	
3. Association of Teachers of Preventive Medicine*	400		
4. Association of University Anesthetists	98	108	
5. Association of University Professors of Neurology*	67		
6. Association of University Professors of Ophthalmology*	85		
7. Association of University Radiologists	314	1000	
8. Joint Committee on Orthopaedic Research and Education Seminars*	475		
9. Society of Academic Anesthesia Chairmen, Inc.	85	850	
0. Society of Chairmen of Academic Radiology Departments	60	960	
1. Society of Surgical Chairmen	86	860	
2. Society of University Otolaryngologists	78	500	
3. Society of University Surgeons	236	236	
4. Society of University Urologists	156	600	
Nonmember			
American Federation for Clinical Research			1000
	15,811	$17,850	$5390

* To advise

[Tab B]

COUNCIL OF ACADEMIC SOCIETIES
Alternatives for the Future*

I. Do away with the CAS and substitute for it an organization of medical school faculty representatives.

   A. Whom would these faculty representatives represent?

      1. Would any attempt be made to balance representation between basic and clinical scientists? How many representatives would there be from each school?

      2. How would the representatives be appointed? Would they be departmental chairmen or junior faculty members? Would they be appointed by the Dean or by some faculty organization such as a faculty council? How would their representativeness be insured?

   B. Who would pay for the travel expenses of these representatives and the costs of the programs to be carried out by them?

II. Retain the CAS.

   A. Whom would the CAS represent?

      1. Have a relatively open membership that would broadly represent those groups of people interested and active in medical education at all levels - undergraduate, graduate, post-graduate, or continuing.

         a. There would be a diversity in the activities and interests of the members, many of whom might have only indirect interest in undergraduate medical education.

         b. It would form a large source of talent and both moral and financial support for carrying out the programs of the CAS.

* Prepared by a Subcommittee of the CAS Executive Committee for discussion by the CAS Executive Committee on February 11, 1971 and by the CAS Membership on February 12, 1971.

[Tab C]

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 14, 1971

TO: Council of Academic Societies

FROM: James V. Warren, M.D., Chairman

SUBJECT: CAS Meeting February 12, 1971, Palmer House, Chicago

Enclosed is a copy of the program and agenda materials for the next CAS meeting. I urge you to plan to attend this important meeting.

The morning session will deal with the changing role of basic science in medical education. The CAS Executive Committee felt that this was an area of urgent consideration by this organization. As part of the current ferment in medical education, we are being asked to reassess the role of basic science. We are being asked to produce medical students with programs of greatly shortened basic science component and the clinical years spent primarily in the community hospitals. Some are either recommending or actually instituting programs with the basic sciences taught by a university or community college some distance from the medical school or by the clinical departments of the medical school. In either way, there is not the immediate resource of a basic science department that we have known so well in recent years. Much basic science teaching is now "verticalized." This has brought changing interrelationships among the basic scientists and the quality control of teaching. These discussions merit the concern and action of both the basic scientist and the clinician.

Even in the short life of the Council of Academic Societies, it has changed appreciably in its make-up and apparent mission. At the CAS annual meeting in Los Angeles, there was considerable discussion regarding the future of the organization, particularly with reference to its membership and goals. In response to a motion passed at that meeting, the Executive Committee appointed a subcommittee to study this issue and prepare several options for the future pattern of the CAS. A copy of this subcommittee's report to the Executive Committee is enclosed so that the membership may have ample opportunity to review it before the February 12 meeting. We would appreciate having your thoughts in this matter. Please write me at the AAMC headquarters. In this way, the Executive Committee can also have the benefit of your thinking at its February 11 meeting, when the report will first be considered. Any plans, of course, must be interdigitated with the total program of the AAMC. If the CAS is to become a useful and productive organization, we should work out a plan which will give both a sense of belonging and a sense of accomplishment to its members. This program will also serve to introduce Dr. August Swanson, who is soon to become a staff member of the AAMC and who will be heavily concerned with its academic activities. Mr. Joseph Murtaugh will attempt to set forth some of the basic issues confronting the further evolution of medical education and research in the context of the broader struggle to arrive at a more comprehensive National Health Policy.

I would again ask that you make every effort to attend and encourage your colleagues to do so. Although the official two representatives from each society are the ones involved in voting at the CAS business meeting, all members of the constituent societies and other interested parties are invited to attend and participate in the deliberations of this meeting.

Encls. Use the hotel reservation card that appears in the AMA brochure.

COUNCIL OF ACADEMIC SOCIETIES
PROGRAM

Palmer House, Chicago, Illinois
PDR 18
February 12, 1971

Morning Session - THE CHANGING ROLE OF BASIC SCIENCE IN MEDICAL EDUCATION

Moderator: Emanuel Suter, M.D.
University of Florida

9:00 a.m.	Introduction	Dr. Suter
9:05 a.m.	Experience at the University of California, San Diego	Clifford Grobstein, Ph.D.
9:25 a.m.	Questions	
9:30 a.m.	Experience at the University of Washington	Thomas Morgan, Jr., M.D.
9:50 a.m.	Questions	
10:00 a.m.	Break	
10:30 a.m.	"A basic scientist looks at his role in medical education"	Manfred Karnovsky, Ph.D. Harvard Medical School
10:50 a.m.	Questions	
10:55 a.m.	"A clinical scientist looks at the role of basic science in medical education"	Donald Seldin, M.D. University of Texas - Southwestern
11:15 a.m.	Questions	
11:20 a.m.	Panel Discussion	
12:15 p.m.	Summary	Dr. Suter

AFTERNOON SESSION
2:00 - 5:00 p.m.
(See over)

COUNCIL OF ACADEMIC SOCIETIES
PROGRAM

Palmer House, Chicago, Illinois
PDR 18
February 12, 1971

Afternoon Session - FUTURE CHALLENGES TO THE CAS

Presiding: James V. Warren, M.D.
Chairman, CAS

2:00 p.m.	Introduction	John A. D. Cooper, M.D. President, AAMC
	"National health policy planning-- a choice between dilemmas"	Joseph S. Murtaugh Director, Department of Planning and Policy Development, AAMC
	"Problems and prospects"	August G. Swanson, M.D. Director, Department of Academic Affairs, AAMC
	* "Future planning"	Sam L. Clark, Jr., M.D. Chairman-Elect, CAS
	Business Meeting Report on Biomedical Research Policy	Louis G. Welt, M.D. Chairman, CAS Committee
	* Report on Graduate Medical Education	Thomas D. Kinney, M.D. Chairman, CAS Committee
5:00 p.m.	Adjournment	

* Agenda materials enclosed

editorials

Basic Science: Medical Practice

Tosteson,[1] in his address before the AAMC Council of Academic Societies last year, approached the problem of organization of the basic medical sciences by demonstrating the relevance of basic science to medical practice. At the outset, he explored the attitudes of the various communities involved in or affected by medical education. The general public, he noted, is disenchanted with medical science because of inadequacies of health care delivery and the failure of research resources to yield more "cures" for the dollars spent. The latter concern has also been reflected in the changing attitude of the federal government where programs of applied research are coming to seem more desirable than those of fundamental research. Meanwhile, physicians practicing medicine outside university walls often take a negative view of support for basic science. Within the institutions responsible for medical education, reactions of administrators, faculty members, and students, although differing in many respects, have been alike in one—a demand for relevance.

Tosteson dismissed as absurd the idea that medical science and medical practice are not related. Rather, he added, they relate in complex ways, two of which seem obvious. First, medical science is a source of new information for the practice of medicine, and the growing knowledge about genetically determined disorders is an excellent example. Prevention and cure of diseases will require more, not less, scientific research. Second, participation in research instills an understanding of the scientific method which Tosteson believes is the best guarantee that a student of medicine will continue to seek knowledge throughout his career.

Having come this far in his statement and analysis of the problem, Tosteson implied a bold challenge to medical educators. He asked that they look to the time when the medical student can acquire, at his own pace, the vocabulary and basic technical knowledge necessary for admission to the clinical years by means of books and teaching machines. Afterward, perhaps as late as the residency years, the student would spend a tutorial year with a basic scientist, thereby coming fully to understand the scientific method.

Tosteson may not have clarified what is relevant in the basic sciences as they are now taught in medical schools. However, he did make clear that basic science and research are relevant to medical practice and the public health, and he gave his audience of medical educators a strong prod to begin thinking about what they are doing.

1. Tosteson DC: The relevance of basic medical science to medical practice. *J Med Educ* **45**:557-563, 1970.

Address editorial communications to the Editor, 535 N Dearborn St, Chicago 60610

[Tab D]

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

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

WASHINGTON: 202: 466-5175

January 4, 1971

AIRMAIL

MEMORANDUM

TO: CAS, COD, & COTH Chairmen; Department and Division Heads, AAMC Staff

FROM: Office of the President

SUBJECT: 1971 ANNUAL MEETING

As you will recall, the Executive Council recently made two policy decisions relating to the 1971 Annual Meeting:

1. In an attempt to reduce the amount of time necessary for members to be away from home base, Council programs will be scheduled simultaneously instead of staggered.

2. To better relate programs to central theme, all AAMC programs will be reviewed by the Annual Meeting Program Committee.

The time frame for the meeting will be:

	Friday	Saturday	Sunday	Monday
A.M.	Plenary	Plenary	Plenary	Other
P.M.	Councils	Assembly	Other	

The Program Committee will meet February 13, 1971 at 7:30 a.m., Room TDR 9, Palmer House Hotel, Chicago. It is hoped that your program plans are far enough along for consideration at this meeting. You are most welcome to attend the meeting to discuss any matters of concern regarding the 1971 Annual Meeting.

BB/ech

cc: 1971 Annual Meeting Program Committee

[Tab E]
January 8, 1971
Draft
CAS Committee on
Graduate Medical
Education

CORPORATE RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

Introduction

The years since the end of World War II have seen the responsibilities of the university-related academic medical complex for all forms of clinical education and training grow. The education and training of these post-doctoral clinical students has become one of the largest programs of the university medical center. Yet the relation of such programs to regulatory agencies independent of the university remains unchanged. Simultaneously problems of financing these programs have become much more involved. The resulting fragmentation of authority and responsibility has been deplored repeatedly. In 1965, in its report, Planning for Medical Progress Through Education, the Association of American Medical Colleges (AAMC) called for broadened university responsibility for graduate medical education (1). The American Medical Association (AMA) has also been deeply concerned with these developments. The two organizations, working in conjunction through the Liaison Committee on Medical Education, have determined to become involved in graduate medical education, initially through careful reexamination of procedures for accreditation of these programs.

1. Coggeshall, L. T. Planning for Medical Progress Through Education. Evanston, Illinois: Association of American Medical Colleges, 1965.

In 1969 the AAMC published a report on The Role of the University in Graduate Medical Education, advocating less fragmentation of authority in this area and focusing of responsibility in the university (2). In light of their growing role in graduate medical education, the component academic medical centers of the AAMC have authorized this statement.

Definition

Corporate responsibility for graduate medical education is defined as the assumption by the university and its collective faculties of the classic responsibilities 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 responsibility for the education of clinical graduate students* (interns, residents, and clinical fellows) 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 or single areas of specialty practice.

Advantages

Among the advantages inherent in vesting responsibility for graduate medical education in a single identifiable body rather than continuing departmental

2. Smythe, C. McC., Kinney, T. D., and Littlemeyer, M. H. The Role of the University in Graduate Medical Education. J. Med. Educ., 44: September, Special Issue, 1969.

* The use of the word student in this document requires definition. The individuals discussed here have received their doctorate and are engaged in an intensive postdoctoral program of training to become a specialist in one of the areas of medical practice. They are basically students, but usually have important commitments to medical care and teaching. They are, therefore, in some sense practicing physicians and faculty members. There is usually no degree goal, but certification by a specialty board or public acceptance of specialty status are the rewards of this training. In view of these considerations, no single word accurately describes persons in this role and with these reservations the word student will be used in this discussion.

fragmentation are the following:

1. implementation of the continuum concept in medical education;

2. more effective adaption to individual student's rates of progress through the education 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; and

7. promotion of a comprehensive rather than a fragmented pattern of medical training and practice.

The major drawback to such an objective is the hazard of incurring some of the inflexibilities of university procedures and/or dangers of bureaucratization.

Fragmentation of Responsibility for Graduate Education

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 of those who make hospital appointments and decide on professional reward systems, both pecuniary and nonpecuniary. 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.

Graduate clinical training or graduate medical education is now carried out in highly variable clinical settings and since the clinical graduate students are frequently licensed physicians but are primarily in a learning role, the status of these students remains ambiguous. Classically, interns and residents are considered employees of hospitals although medical schools or other professional groups may contribute to their stipends. Interns and residents are denied the practice privileges of physicians not in teaching programs, especially as regards the management of fees for services to patients. They are not usually considered members of the university community especially as regards the management of fees for services to patients, yet their salaries are largely derived from third-party payments based on patient services. Still these students are not usually considered members of the university community.

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, progress through training, and determination of elegibility for admission to the specialty board examinations are now determined largely by individual boards. Such boards are char-

acteristically private, not-for-profit organizations that have substantial autonomy. Universities or hospitals have no direct influence on their policies or actions.

All internships are approved by the Internship Committee of the Council on Medical Education of the AMA. All residency programs are accredited by the Residency Review Committees of the AMA, with the exception of Pathology. The American Board of Pathology directly examines and accredits its residency training programs. The Residency Review Committees are made up of appointees of the specialty sections of the AMA and the appropriate boards, and many of them also have additional appointees from the appropriate Colleges or Academies. The Residency Review Committees are autonomous except for matters of policy and do not have to report back to their parent organizations for ratification of their decisions. The graduate education section of the Council on Medical Education of the AMA 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 direct authority over either the boards or the Residency Review Committees since both function independently and autonomously. However, in practice, its influence is significant. It should be noted that the AMA 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 secondary 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 in accord with the requirements of the specialty boards and the Residency Review Committees. Although service chiefs may work closely with members of their own departments, insofar as content and process of residency education, such chiefs have a considerable autonomy within broad policies.

The medical school or university through its faculty members and affiliated hospitals sponsors and influences a large segment of graduate medical education and accordingly should have a more formal role in its design and operation. 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. Its faculty as a group may have no corporate responsibility.

In summary, control of graduate medical education is fragmented among the following settings:

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. Residency Review Committees which accredit on a programmatic basis and which in the long haul are answerable to the interests of the practicing profession;

4. service chiefs who on a programmatic basis determine the balance of content and all of the process of graduate medical education; and

5. medical schools and universities which exert considerable authority through the individuals whom they appoint but accept little direct operational responsibility as institutions.

Attributes of Current System

Today's system has consistently and reliably produced specialists well equipped to care for the disease-related content of their areas of medical practice. 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, the replication of highly categorized specialists were now acceptable in terms of the needs of the public, its ambiguities would be tolerable.

Before any new arrangement is adopted, in terms of its stated objectives, it should be noted that these are major strengths of this pluralistic system. 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 helped produce a medical care system with serious imbalances.

Unification or Corporate Responsibility in Undergraduate Medical Education

In many ways the situation in graduate medical education today is not unlike that of undergraduate medical education 70 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 the 1970's 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. In the 1960's medical schools began major undergraduate curricular revisions. These efforts to make undergraduate education more responsive to perceived public needs are generally based on the assumption that the undergraduate educational process is preparing students to enter into a period of postdoctoral training. This combination of predoctoral and postdoctoral education finally produces the polished professional clinician, and the professional school should have as large a stake in the postdoctoral educational process as it has had in the predoctoral.

Corporate Responsibility

Corporate responsibility has been defined for the purposes of this paper as institutional as opposed to departmental or proprietary assumption of the recognized 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; and
7. designation of completion of program.

These responsibilities as applied to graduate medical education should be vested in a university and then should be delegated to its medical faculty which in turn should create a program of educational advancement protecting the rights of students and responsive to the requirements of society.

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

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

Administrative, financial, and organizational relations existing between parent universities and their medical schools would not be appreciably altered by this change. 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 clinical 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 nonmedical, 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, and examinations.

The advocated organizational patterns can be counted on to precipitate decisions about which aspects of general surgery and medicine should precede and which should follow the M.D. degree. The questions must be faced in any event, and recognition of medical education as a continuum--the responsibility of a single unified faculty--would be a great advantage.

The Graduate School

Assignment of such corporate responsibility within the university will become an important consideration. Although it is conceivable that the graduate school could be the assigned area for such programs, graduate clinical education is so eminently the business of physicians that it makes little sense to locate it in a general university graduate school but rather to retain it in the medical school setting. Actually multiple solutions are possible, and 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. The public has a firm impression of the meaning of the M.D. degree, and any change in university structure that might alter its denotation should be considered with circumspection.

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 program will call for intensive bargaining. 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 University, Graduate Education, and Nonaffiliated Hospitals

Although the university medical center initially assumes a corporate responsibility for the graduate education of physicians in its affiliated hospitals, ultimately the need for the university's influence on graduate programs in nonaffiliated hospitals will be necessary for several reasons:

1. A considerable segment of all graduate education is now conducted in nonaffiliated hospitals.

2. University medical centers and their affiliated hospitals cannot educate effectively the total number and type of physicians required.

The relationship created can vary from one institution to another depending upon the educational capability of the nonaffiliated hospital, financial support required, and the desire of the nonaffiliated hospital to participate in a university designed and directed educational program. All such arrangements for cooperative or integrated efforts should be completely voluntary and obviously to the advantage of both institutions.

The Student

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 students 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. These university procedures would carry with them the benefits of easier access to all the strengths of the university.

Financing the Educational Component

There is obviously a cost involved in graduate medical education. For years this cost has been absorbed by the residents by deferral of earnings, by the clinical faculties through donation of their time, and by the patients, especially those in tax and philanthropically supported hospitals, through direct charges for hospital services. This system is now challenged by everyone: the residents in their demand for higher salaries, the faculties through the emergence of the full-time system, and the patients who through large third-party payers are challenging the inclusion of any educational costs in charges to patients.

The organization of clinical faculties along corporate rather than departmental lines would have no direct effect on these issues, except for their probable clarification. Expenses should not increase except as academic functions increase. The emerging acceptance of the need to fund service functions by beneficiaries of these services and educational functions by the beneficiaries of these services will shortly bring to a head responsibility for funding of this educational component.of clinical graduate

training. The university will be unable to assume this burden unless it in turn is financed. The general trend to spread costs of higher education widely through society by any of a number of mechanisms is seen as the only way to handle this issue.

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. The boards will continue to have a major role in graduate medical education through the design and provision of examinations and the certifying of candidates who complete them successfully.

External Accrediting Agencies

The Liaison Committee on Medical Education, the Council on Medical Education of the American Medical Association, Residency Review Committees, and the Joint Commission on Hospital Accreditation are examples of external accrediting agencies. 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. The Liaison Committee on Medical Education

is taking some steps to assure greater responsibility for accreditation in graduate medical education.

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.

The Academic Health Center and Graduate Medical Education

The progressively more secure conviction by the Association of American Medical Colleges that the academic health center should become a focal point for the initiation and operation of programs for research, education, and patient services on a regional basis creates questions concerning goals and methods of attaining them. For the center to have a significant influence upon the regional practice of medicine and the delivery of comprehensive health services, it appears essential for the center and specifically the university to assume a corporate responsibility for the graduate education of physicians. Among the reasons for the need for this assumption are the fact that (a) a portion, frequently a large one, of the service provided to the community is carried out by interns and residents; (b) the total interdisciplinary resources of the university can be brought to bear upon the standards of health care through interns and residents; and (c) a continuing relationship for educational purposes may be created through interns and

residents when they enter the community to practice.

Without the university's acceptance of the corporate responsibility for the total formal education of physicians, their efforts to influence services provided to the community and the appropriate education of physicians to provide them will be less than effective.

52 choices
Need 16 names [Tab F]

1971-72
COUNCIL OF ACADEMIC SOCIETIES
Ballot
Election of New Officers

CHAIRMAN, CAS
ONE-YEAR TERM

Sam L. Clark, Jr. _____

VOTE FOR ONE

SECRETARY-TREASURER, CAS
ONE-YEAR TERM
(To replace Weil*)

_____ _____
_____ _____

VOTE FOR ONE

CHAIRMAN-ELECT, CAS
ONE-YEAR TERM
(Should be 2 clinical scientists)

_____ _____
_____ _____

VOTE FOR ONE

TWO-YEAR TERM ON EXECUTIVE COMMITTEE OF CAS
(Nominate 2 for each place to be filled)

_____ _____] Two basic scientists to replace Fitzgerald*
_____ _____]

VOTE FOR TWO

_____ _____] Four clinical scientists to replace Gregory* & Longmire*
_____ _____
_____ _____
_____ _____]

VOTE FOR ONE

CAS REPRESENTATIVES TO THE EXECUTIVE COUNCIL OF THE AAMC
(To replace Kinney - should be 2 basic scientists - should not be add'l, but should be someone on CAS Executive Committee)

_____ _____
_____ _____

Also, last year the CAS Nominating Committee was asked to put up one name from CAS membership to the AAMC Nominating Committee for Chairman of the AAMC Assembly. This name does not go on the CAS ballot, however.

The current balance is:

CAS Executive Committee consists of 9 members:

5 clinical scientists
4 basic scientists

plus two ex officio members, one each basic scientist (Kinney) and clinical scientist (Rhoads). Kinney rotates off.

Executive Committee may serve for 3 terms.

* Eligible for reelection

2/5/71

COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

C = Current member Exec Cte
F = Former member Exec Cte

1. Academic Clinical Laboratory Physicians and Scientists
   1. Dr. George Brecher, University of California, San Francisco

2. American Association of Anatomists
   2. Dr. Burton L. Baker, University of Michigan, Ann Arbor
   C — 3. Dr. Sam L. Clark, Jr., University of Massachusetts, Worcester

3. American Association of Chairmen of Departments of Psychiatry
   4. Dr. Bernard C. Holland, Emory University, Atlanta
   5. Dr. L. Jolyon West, University of California, Los Angeles

F — 4. American Association of Neurological Surgeons
   ~~6.~~ Dr. Eben Alexander, Jr., Bowman Gray, Winston-Salem
   7. Dr. Henry G. Schwartz, Washington University, St. Louis

5. American Association of Neuropathologists
   8. Dr. George H. Collins, University of Florida, Gainesville
   9. Dr. Wolfgang Zeman, Indiana University, Indianapolis

6. American Association of Pathologists and Bacteriologists
   10. Dr. Kenneth M. Brinkhous, University of North Carolina, Chapel Hill
   C — ~~11.~~ Dr. Patrick J. Fitzgerald, SUNY-Downstate Medical Center, Brooklyn

7. American Association of Plastic Surgeons
   12. Dr. James E. Bennett, Indiana University, Indianapolis
   13. Dr. Stephen Lewis, University of Texas, Galveston

8. American Association of University Professors of Pathology
   C — 14. Dr. Thomas D. Kinney, Duke University, Durham

9. American Neurological Association
   15. Dr. Kenneth Magee, University of Michigan, Ann Arbor
   16. Dr. Samuel A. Trufant, University of Cincinnati, Cincinnati

10. American Pediatric Society
   17. Dr. Charles A. Janeway, Children's Hospital Medical Center, Boston
   C — 18. Dr. William B. Weil, Jr., Michigan State, East Lansing

11. American Physiological Society
   19. Dr. R. E. Forster, University of Pennsylvania, Philadelphia
   20. Dr. Arthur B. Otis, University of Florida, Gainesville

12. American Society of Biological Chemists, Inc.
   C — 21. Dr. Ronald Estabrook, University of Texas, Dallas
   22. Dr. Robert Harte, American Society of Biological Chemists, Inc. (Exec. Secy - NOT in a school)

13. American Surgical Association
   23. Dr. William D. Holden, Case Western Reserve University, Cleveland
   24. Dr. Lloyd Nyhus, University of Illinois, Chicago

14. Association for Medical School Pharmacology
   25. Dr. George H. Acheson, University of Cincinnati, Cincinnati

15. Association of Academic Physiatrists
    26. Dr. Murray M. Freed, Boston University Medical Center, Boston

16. Association of American Physicians
    27. Dr. Eugene A. Stead, Duke Hospital, Durham
    28. Dr. Louis Welt, University of North Carolina, Chapel Hill

17. Association of Anatomy Chairmen
    29. Dr. Jack Davies, Vanderbilt University, Nashville
    30. Dr. David G. Whitlock, University of Colorado, Denver

18. Association of Chairmen of Departments of Physiology
    31. Dr. Robert Berne, University of Virginia, Charlottesville
    32. Dr. D. C. Tosteson, Duke University, Durham

19. Association of Medical School Pediatric Department Chairmen, Inc.
    33. Dr. William Thurman, University of Virginia, Charlottesville
    34. Dr. Ralph J. Wedgwood, University of Washington, Seattle

20. Association of Professors of Dermatology
    35. Dr. Phillip C. Anderson, University of Missouri, Columbia
    36. Dr. Raymond R. Suskind, University of Cincinnati, Cincinnati

21. Association of Professors of Gynecology and Obstetrics
    37. Dr. John Donovan, University of Rochester, Rochester

22. Association of Professors of Medicine
    38. Dr. Ludwig Eichna, SUNY-Downstate Medical Center, Brooklyn
    39. Dr. Robert Petersdorf, University of Washington, Seattle

23. Association of Teachers of Preventive Medicine
    40. Dr. Charles E. Lewis, UCLA, Los Angeles
    41. Dr. Kenneth Rogers, University of Pittsburgh, Pittsburgh

24. Association of University Anesthetists
    42. Dr. John J. Bonica, University of Washington, Seattle
    43. Dr. Robert M. Epstein, Columbia University, New York

25. Association of University Professors of Neurology
    44. Dr. Maynard Cohen, University of Illinois, Chicago
    45. Dr. David Daly, University of Texas, Dallas

26. Association of University Professors of Ophthalmology
    46. Dr. Frank C. Newell, University of Chicago, Chicago,
    47. Dr. David Shoch, Northwestern University, Chicago

27. Association of University Radiologists
    48. Dr. John A. Campbell, Indiana University, Indianapolis
    49. Dr. Solomon Schwartz, Yale University, New Haven

28. Joint Committee on Orthopaedic Research and Education Seminars
    50. Dr. Paul H. Curtiss, Jr., Ohio State University, Columbus
    51. Dr. Charles F. Gregory, University of Texas, Dallas

29. Society of Academic Anesthesia Chairmen, Inc.
    52. Dr. Peter P. Bosomworth, University of Kentucky, Lexington
    53. Dr. Frank Moya, University of Miami, Miami

30. Society of Chairmen of Academic Radiology Departments
    54. Dr. Herbert L. Abrams, Harvard Medical School, Boston
    55. Dr. Sidney W. Nelson, Ohio State University, Columbus

31. Society of Surgical Chairmen
    56. Dr. G. Tom Shires, University of Texas-Southwestern, Dallas
    57. Dr. David C. Sabiston, Jr., Duke University, Durham

32. Society of University Otolaryngologists
    58. Dr. Roger Boles, University of Michigan, Ann Arbor
    59. Dr. James B. Snow, Jr., University of Oklahoma, Oklahoma City

33. Society of University Surgeons
    60. Dr. Theodore Drapanas, Tulane University, New Orleans
    61. Dr. Richard H. Egdahl, Boston University, Boston

34. Society of University Urologists
    62. Dr. William Boyce, Bowman Gray, Winston-Salem
    63. Dr. John T. Grayhack, Northwestern University, Chicago

* CAS NOMINATING COMMITTEE
1971-72

Basic Sciences

Dr. George H. Acheson, Association for Medical School Pharmacology
University of Cincinnati, Cincinnati

Dr. R. E. Forster, American Physiological Society
University of Pennsylvania, Philadelphia

Dr. Thomas D. Kinney, American Association of University Professors
of Pathology, Duke University, Durham

Dr. D. C. Tosteson, Association of Chairmen of Departments of Physiology
Duke University, Durham

Clinical Sciences

Dr. Eben Alexander, Jr., American Association of Neurological Surgeons
Bowman Gray, Winston-Salem

** Dr. Richard H. Egdahl, Society of University Surgeons
Boston University, Boston

Dr. Ralph J. Wedgwood, Association of Medical School Pediatric Department
Chairmen, University of Washington, Seattle

* Elected December, 1970
** Chairman

Miss Fitzsimmons
[Tab 6]

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

MEMORANDUM

TO: Council of Academic Societies

SUBJECT: National Health Insurance

DATE: 23 December 1970

Attached you will find the general position of the Association of American Medical Colleges in reference to National Health Insurance.

We are presently involved in reviewing the various proposed pieces of legislature applying these principles in greater specificity, the results of which will be made available to you.

John M. Danielson
Director, Department of Health Services and Teaching Hospitals

Attachment

cc: Dr. J. A. D. Cooper

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

POSITION ON NATIONAL HEALTH INSURANCE

The Association of American Medical Colleges represents the nation's 107 medical schools, 390 of our leading teaching hospitals, and 34 academic societies of both the basic science and clinical disciplines. Because of this broad representative base, I believe we can effectively speak for the academic medical center which includes the medical school, the faculty and the teaching hospital.

The AAMC's formal concern with the issue of national health insurance dates back to September of 1969.

At a meeting on Sepbember 17, 1969, the Executive Council of the Association of American Medical Colleges unanimously passed the following resolution:

> The Executive Council approves in principle a universal health insurance program for all citizens as a proper and necessary step in having the best possible health care for the people, which is the principal objective of the Association. The Executive Council recommends that the Assembly approve, itself, the same position.

It was recommended that:

(a) Emphasis must be placed on redirecting the prevailing patterns of health care from "crisis medicine" to anticipatory care.

(b) The essential role of academic medical centers and teaching hospitals in producing the manpower necessary to meet the expanded demands on the health care system that will inevitably occur must be recognized.

(c) Reimbursement for appropriate costs of the delivery of health care should be provided. The pattern of reimbursement must be compatible with and supportive of the systems of finance for education and training programs conducted in close relationship to the delivery of care in the teaching setting.

(d) The necessity for supporting research, demonstration projects and innovations in systems of health care delivery designed to increase its quantity, quality, and equality should be an integral part of any plan.

On November 3, 1969, the Assembly, the constituent delegate body of the Association, unanimously approved this same resolution. At that time an ad hoc committee was appointed to develop a more detailed position statement within the guidelines of the approved resolution.

The Ad Hoc Committee on National Health Insurance held its first meeting on February 19, 1970, under the chairmanship of Dr. Carleton B. Chapman, Dean of the Dartmouth Medical School. At this meeting, the following statement of principles was developed:

> "The Ad Hoc Committee on National Health Insurance of of AAMC supports the principle of National Health Insurance for all citizens as a significant opportunity to improve the health care of the American people. It must be recognized that such improvement in health care will not automatically follow the institution of National Health Insurance. Therefore, to insure improvement in health care, the plan adopted must be structured so as to provide incentives and support for a health care system with the following minimal characteristics:
>
> 1. Access to needed care without regard to economic circumstances of the individual.
> 2. Planned community programs providing a full range of services with appropriate attention to individual and group preventive measures.
> 3. Efficient and effective use of health resources.

4. Public accountability combined with appropriate balance between professional and consumer participation in program development.
5. Development and implementation of priorities for achievement of specific health goals established at national, state and local levels.
6. Provision for systematic evaluation with adequate flexibility to respond to changing opportunities and needs.
7. Recognition of the dependence of the system on the education of adequate numbers of health professionals and the continuous generation of biomedical knowledge.
8. Capitalize on the strength of the current system of financing health care and encourage appropriate substitution for the areas of weak financing recognizing that a single source of financing is self-limiting and a pluralistic financing system is preferable.

Stated above are the eight minimal characteristics which the AAMC believes are necessary in the development of any national health insurance program which is adopted. Each member of the Ad Hoc Committee has agreed to develop a more definitive exposition of these characteristics for review at a September, 1970 meeting of the Committee.

We do not have the staff necessary to prepare a detailed plan of financing and delivery. However, we do believe these are eight points which must be considered. It is clear that there is currently developing a broadly based mandate of support for some type of national health insurance program

It is naive to believe that such legislation will not strain the present system of providing health services. The AAMC views with great concern the fact that similar support is not evident to provide pressure for the development and financial support of manpower to staff the services which are expected to be provided.

Over sixty percent of present health care costs are directly attributed to manpower. It must be the prime target for reform and development. All levels of government in recent years have been committed to provide more and more services. Too often there has not been concommitant concern with the development of manpower to provide these services. A variety of mechanisms have been introduced to deal with this inadequacy. These mechanisms have included proposals to build the financing of education costs into charges for patient services, to tax a percentage or all of any governmentally sponsored service program and allocate this tax to manpower educational purposes, or to support educational programs with direct appropriations. Each of these proposals, as well as others, has both short-term and long-term implications in the allocation of the health education dollar. It is apparent that no matter what form the issue eventually takes, it is one that will necessarily have to be carefully dealt with.

In addition, the problem this nation faces is not only one of the quantiative aspects of physician manpower. The problem is also one of manpower utilization. The present geographic and specialty distribution of physicians is a critical issue. Furthermore the American public has long undergone an education which had, as its focal point, the concept that high quality medical care can result only from a one-to-one relationship between physicians and patients. This factor, accompanied by the inflexibility of licensure, accreditation and legal responsibility has

led to the resistance which appeared when physicians are asked to delegate specific tasks in the management of patients. These difficulties, as the Office of Emergency Prepared knows well, are often highlighted in the provision of emergency services.

In summary, the position of the Association of American Medical Colleges is:

1. Implementation of a National Health Insurance program will not automatically result in improved health care for the American public;

2. Eight minimal characteristics have been outlined which must be considered in the development of any National Health Insurance program;

3. A concern that the mandate for a National Health Insurance program has not been matched with a concommitant mandate to provide support for the development of manpower to provide the expanded services which are expected to be rendered.

[Tab H]

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

December 30, 1970

To: Secretaries, Constituent Organizations
Council of Academic Societies

From: Thomas J. Campbell, Assistant Director
Division of Operational Studies

Subj: AAMC Faculty Salary Study

Each year the Division of Operational Studies of the Association of American Medical Colleges collects salary data from each of the American medical schools and publishes for the use of the deans of those schools, a confidential salary survey, listing salary ranges by department by professional rank. Because we are in the process of refining our reports in an attempt to produce more complete and accurate information, a great deal of interest has been generated in salary studies that may have been done by other organizations for purposes of comparison.

I am writing at this time to request any information in the form of faculty salary studies which have been done by other groups, yours in particular, in order to help ascertain the validity of our data. Any salary studies which you can provide will be used internally in the AAMC and confidentiality preserved.

I shall appreciate any effort on your part to provide us with any available salary studies, and look forward to hearing from you.

jj

cc: Official Representatives
Council of Academic Societies

bcc: William D. Mayer, M.D., Dean
University of Missouri School of Medicine
Stadium Road
Columbia, Missouri 65201

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 22, 1971

TO: CAS Executive Committee

James V. Warren, M.D., Chairman
Sam L. Clark, Jr., M.D.
Ronald W. Estabrook, Ph.D.
Patrick J. Fitzgerald, M.D.
Charles Gregory, M.D.
Thomas D. Kinney, M.D.
Ernst Knobil, Ph.D.
William P. Longmire, Jr., M.D.
Jonathan E. Rhoads, M.D.
William B. Weil, Jr., M.D.
Louis G. Welt, M.D.

FROM: Mary H. Littlemeyer, Senior Staff Associate

SUBJECT: Next Meeting
April 9, 1971 (Good Friday)
10:00 a.m. - 4:00 p.m.
O'Hare Airport, Chicago, Illinois

This is to confirm the next meeting of the CAS Executive Committee to be held on April 9 (Good Friday), 10:00 a.m. - 4:00 p.m., O'Hare Airport, V.I.P. room, Mezzanine Level, Rotunda Building, adjacent to the Seven Continents Cocktail Lounge. The meeting will be posted at the foot of the escalator, Association of American Medical Colleges. The meeting room will be open for use any time after 7:00 a.m. Coffee and breakfast rolls will be served at 9:45 a.m.

For those of you who were unable to attend the CAS Executive Committee, in Chicago last week, the date of April 15, previously held for the next meeting of the Committee, was changed to April 9 due to the Federation meetings.

Please return the enclosed form to me (self-addressed envelope attached) relative to your attendance. We are not making hotel reservations for you, since many of you will already be in Chicago for the Federation meetings, and others will be able to fly in and out the same day.

cc: John A. D. Cooper, M.D.
John M. Danielson, M.D.
James B. Erdmann, Ph.D.
Davis G. Johnson, Ph.D.
Joseph S. Murtaugh
August G. Swanson, M.D.
Marjorie P. Wilson, M.D.

Return to Mary Littlemeyer, AAMC, Room 200, One Dupont Circle, N.W. Washington, D. C. 20036 (envelope enclosed)

Re: Meeting, CAS Executive Committee
James V. Warren, Chairman

April 9, 1971 (Good Friday)
10:00 a.m. - 4:00 p.m.
O'Hare Airport, Chicago, Illinois
V.I.P. room
Mezzanine Level
Rotunda Building

_____I will attend the above meeting

_____I will not attend the above meeting

_____
Signed

_____
Date

MINUTES
EXECUTIVE COMMITTEE
COUNCIL OF ACADEMIC SOCIETIES
February 11, 1971

Palmer House Hotel
Chicago, Illinois

Present: Committee Members

James V. Warren, Chairman (Presiding)
Sam L. Clark, Jr.
Ronald W. Estabrook
Patrick J. Fitzgerald
Charles Gregory
* Thomas D. Kinney
Ernst Knobil
William P. Longmire
William B. Weil
Louis G. Welt

Staff

Connie Choate
Mary H. Littlemeyer
Joseph S. Murtaugh
August G. Swanson

Absent: Committee Members

* Jonathan E. Rhoads

* Ex Officio

I. Adoption of Minutes

The minutes of the CAS Executive Committee meeting held December 15, 1970 were adopted as circulated.

II. Report, Subcommittee on CAS Future Structure & Objectives

The Executive Committee had authorized preparation by a subcommittee of a document setting forth alternatives for the future of the CAS in response to the "Wedgwood motion" in Los Angeles. Drs. Warren and Clark had met subsequently and drafted such a statement. The statement was then sent to the CAS Membership clearly marked as a discussion item for the CAS Executive Committee on February 11 and the CAS Membership on February 12.

A great deal of discussion ensued focused primarily on Dr. Kinney's objection to the preparation of the statement by less than the full subcommittee and to the manner in which it went out to the Membership. The alternatives set forth in the document were not discussed per se. It was agreed that the discussion by the CAS Membership should be limited to 30 minutes

and that in introducing the discussion it would be pointed out that the alternatives had been prepared in response to the "Wedgwood motion," approved in Los Angeles, to serve as the basis for future planning by a committee of the Executive Committee.

III. Planning Future Meetings

The next Annual Meeting of the CAS will be Friday afternoon, October 29, Washington Hilton Hotel, Washington, D. C. The Executive Committee explored a number of topics. The majority favored Item 3.

1. The Government and Academic Medicine
2. Financing Service, Research, & Teaching
3. New Technology and the Educational Process (with exhibits)
4. Disadvantaged Students, Enrichment of Learning, Multiple Track, Social Adjustment
5. Mechanisms of Curricular Changes and Evaluation
6. Explicit Statement of Goals & Evaluation
7. Medical Research
8. Where Do the Health Sciences Professions Fit In?

IV. Report, Committee on Graduate Medical Education

Dr. Kinney, Chairman of this Committee, reported on the development of the white paper, "Corporate Responsibility for Graduate Medical Education," which was revised by the Committee on January 8, 1971. Copies of the revised paper had been distributed to the membership of the three AAMC Councils.

To Dr. Fitzgerald's question of whether the universities could finance it, Dr. Kinney responded that the paper only outlines the problems as they exist. Dr. Gregory felt that the paper, if distributed widely, would be interpreted as AAMC policy rather than a statement of the implications of the corporate responsibility for graduate medical education. Dr. Longmire felt it was an excellent review of the subject but an inopportune time to take on this particular aspect of medical training which fundamentally has been working very well. Dr. Kinney pointed out that this draft was merely a revision of an earlier statement that the CAS had approved.

ACTION: On motion, duly seconded, the Executive Committee voted unanimously to revise the title of the paper to "The Implications of the Corporate Responsibility for Graduate Medical Education."

ACTION: On motion, duly seconded, the Executive Committee voted unanimously to reaffirm its approval of the document as modified on January 8, 1971, and to recommend its approval by the CAS Membership on February 12, 1971.

V. Report, Nominating Committee

The CAS Nominating Committee for 1971-72 will meet to prepare its slate on March 4, 1971. Its members are:

Basic Sciences

Dr. R. E. Forster, American Physiological Society
University of Pennsylvania, Philadelphia

Dr. Thomas D. Kinney, American Association of University Professors of Pathology, Duke University, Durham

Dr. D. C. Tosteson, Association of Chairmen of Departments of Physiology
Duke University, Durham

Dr. David G. Whitlock, Association of Anatomy Chairmen
University of Colorado, Denver

Clinical Sciences

Dr. Richard H. Egdahl, Society of University Surgeons
Boston University, Boston

Dr. John T. Grayhack, Society of University Urologists
Northwestern University, Chicago

Dr. Ralph J. Wedgwood, Association of Medical School Pediatric Department Chairmen
University of Washington, Seattle

VI. Report, Committee on Biomedical Research Policy

Dr. Welt, Chairman of the Committee, described the current status of this effort.

1. An edited and expanded report was distributed to the Executive Committee. Dr. Swanson will investigate the possibility of its publication in the Journal of Medical Education.

ACTION: On motion, duly seconded, the Executive Committee accepted the edited and expanded Committee Report as distributed. Any objections upon further review were to be forwarded in writing to the AAMC staff.

2. A draft questionnaire based on the Committee's survey has been submitted for publication in Science.

3. Health economists are eager to show the savings to the nation (GNP) through health. Funding efforts for this have been unsuccessful. Dr. Swanson will explore this with staff.

4. As requested by Dr. Estabrook, Dr. Welt will draft a short (six sentence) summary describing the Committee's activities.

5. Since the agenda was distributed additional contributions from constituent organizations to support the Committee had been received, bringing the total receipts to date to $18,835. The only organizations which had not contributed funds were:

1. American Association of Neurological Surgeons
2. American Association of Neuropathologists
3. American Association of Pathologists and Bacteriologists
4. American Neurological Association
5. American Pediatric Society
6. American Society of Biological Chemists, Inc.
7. American Surgical Association
8. Association for Medical School Pharmacology
9. Association of Medical School Pediatric Department Chairmen, Inc.
10. Association of Professors of Dermatology
11. Association of Professors of Gynecology and Obstetrics
12. Association of Teachers of Preventive Medicine
13. Association of University Professors of Neurology
14. Joint Committee on Orthopaedic Research & Education Seminars

Finally, the Executive Committee discussed the Cancer Authority (S 34) and the dire consequences of such legislation.

ACTION: On motion, duly seconded, the Executive Committee resolved that the implications of the proposed "Cancer Authority" legislation are of such an order of magnitude that it demands immediate attention by the AAMC. There would be a committee prepared to implement the collection of data and develop them for consideration by the AAMC. This committee would be offering their services but are not proposing action.

NOTE: A resolution adopted by the Assembly of the AAMC on February 13, 1971, was reproduced in the Congressional Quarterly for February 18, 1971 Because of its import, it is reproduced here.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES.
Washington, D.C., February 16, 1971.

A RESOLUTION ADOPTED BY THE ASSEMBLY OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON THE FIGHT AGAINST CANCER

Cancer is the second leading cause of death in the United States. The search for the causes and the cure of cancer, which spreads over all ages, is a scientific endeavor worthy of our greatest efforts.

New scientific leads, if fully and comprehensively exploited, may make it possible to achieve more adequate preventive and therapeutic capability for coping with this disease.

The present state of our understanding of cancer is a consequence of broad advances across the full scope of the biomedical sciences. In preparing for a greater effort, it is of the utmost importance to understand that despite the progress thus far made, the basic nature and origins of cancer are still not known. The kind of scientific formulation that permitted the development of nuclear energy and that underlies our space exploration does not exist for cancer. Further advance in fundamental biomedical sciences is essential to the solution of the unsolved problems that limit our ability to control cancer. Thus, the development of a special and extraordinary national program in cancer should be in the context of broad support of the related and underlying fields of scientific effort and in an organizational framework which assures sound direction and leadership in advancing this complex set of interrelationships.

The framework of the NIH, which had its origins with the Act of 1930, enlarged by the National Cancer Act of 1937, and the successive statutes creating the several categorical institutes in the post-war period, has made it possible to bring into being the most productive scientific community centered upon health and disease that the world has ever known. It is precisely because this organization has assured a close integration between fundamental scientific endeavor and organized attack upon specific disease problems that this extraordinary blossoming of medical science, and thus our medical capability, has taken place.

Therefore be it resolved that the Association of American Medical Colleges wholeheartedly endorses Federal support of a broad-based and intensive attack on the cancer problem called for by President Nixon in his State of the Union Message and of the magnitude envisaged in the report of the National Panel of Consultants on the Conquest of Cancer, and that this major expansion be undertaken as an integral part of the existing national framework for the advancement of biomedical knowledge for the nation's health as provided by the structure of the NIH and the National Cancer Institute.

VII. Teaching Institutes

Dr. Estabrook again expressed interest in institutes such as were conducted under AAMC aegis beginning in the mid-1950's He and Dr. Swanson will discuss this further, and the institute idea will be placed on the agenda of the next Executive Committee meeting.

VIII. Next Meeting

Because of the Federation meetings, the next meeting of the CAS Executive Committee will be held in Chicago on April 9.

IX. Adjournment

The meeting was adjourned at 10:45 p.m.

3/5/71
MHL/s1

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

COUNCIL OF ACADEMIC SOCIETIES
Executive Committee Agenda

Place: V.I.P. Room, Mezzanine Level, Rotunda Building, O'Hare Airport, Chicago, Illinois

Time: 10:00 a.m. - 4:00 p.m., April 9, 1971

Discussion Items:

*1. Relationship between the CAS and the possibly-to-be-formed Organization of Faculty Representatives.

*2. Changing the time and place of the AAMC February - Chicago meeting.

*3. Establishing clearly defined procedures for the admission of societies to the CAS in the future.

*4. Changing the CAS constitution and by-laws to make them consistent with the AAMC constitution and by-laws.

*5. Designation of delegates to the AAMC Assembly.

6. Institutes in Medical Education - a future CAS-AAMC enterprise.

Progress Reports:

1. Status of Development of the Department of Academic Affairs - Dr. August G. Swanson.

2. Status of Development of policy on Corporate Responsibility for Graduate Medical Education - Dr. Swanson

3. Status of Development of the Program for the Annual Meeting - Dr. Swanson

Information Items:

1. Current status of Health Legislation - Dr. Cooper

2. Nominating Committee Report

3. National Library of Medicine Committee report.

*Comments attached.

Comments for Executive Committee Agenda
April 9, 1971

1. Relationship between the CAS and the possibly-to-be formed Organization of Faculty Representatives.

At the February meeting of the AAMC the Assembly authorized the establishment of an Organization of Student Representatives. This Organization is to provide student representation to the AAMC from medical schools. These students will represent their institutions and presumably the student bodies of those of the institutions. This action also provided for ten votes in the Assembly for the Organization of Student Representatives. The OSR will be a subsidiary of the Council of Deans. This arrangement was deemed logical because deans are also institutional representatives of the schools of medicine.

At the time of the adoption of this new organization, another motion was passed ordering the Executive Council to explore the possibility of establishing an Organization of Faculty Representatives.

At its inception, the Council of Academic Societies was viewed as the council providing faculty input to the AAMC. Indeed that is mentioned in the first sentence of the Preamble of the Constitution of the CAS. In many ways the Council has represented the faculties of the Nation's medical schools. Its programs, which have dealt frequently with educational matters, are evidence of the concern of the Council with the educational process.

However, there has been criticism of the fact that the members of the Council are largely drawn from the more senior members of the academic community and, in fact, many are Chairmen of departments. In addition, since the Council is constitutionally made up of individuals representing particular academic disciplines, it is viewed as a group of discipline-oriented societies rather than of faculties. The development of an Organization of Faculty Representatives is directed towards bringing into the AAMC individuals who will represent the views of their faculty colleagues at their specific institutions. Presumably many of these representatives would be from the younger faculty.

It appears there is a place for both the Council of Academic Societies and an Organization of Faculty Representatives. The Council does represent itself as a consortium of academic societies concerned with medical education. Ideally, the views and concerns of each individual discipline represented by the member societies are brought to the Council to guide it in its deliberations. This disciplinary view is important and necessary to the AAMC. An Organization of Faculty Repre-

sentatives placed as a subsidiary of the Council of Deans would bring to the AAMC the views of faculties regarding their institutional goals and problems.

Dr. Anlyan and Dr. Cooper will be present at the meeting and are particularly anxious to discuss this item thoroughly.

2. Changing the time and place of the AAMC February - Chicago meeting.

The traditional meeting of the AAMC in conjunction with the AMA's Congress on medical education has been negatively commented upon by many individuals. The principal problem is the timing of the Congress. This meeting, which occurs only three-and-one-half months after the major AAMC Annual Meeting makes the development of a program difficult. In addition, such a short period between the two major meetings of the AAMC does not allow enough time for the development of policy resolutions pertinent to new and challenging problems. It also means that there is a long eight-and-one-half month hiatus between major meetings.

It has been suggested that the secondary AAMC meeting should be pushed back into late March, May or June and that the site for the meeting should be varied from Chicago.

3. Establishing clearly defined procedures for the admission of societies to the CAS in the future.

Considerable dyspareunia resulted from the last round of society admissions to the CAS. At the February meeting the discussion of the future of the CAS by the Council clearly indicated that the activities of the Council should proceed in much the same fashion as in the past. It was recommended that clearer guidelines be developed for admission of societies to the CAS. The establishment of clear and comprehensive guidelines appears difficult; and it is suggested that in lieu of establishing such guidelines, a regularized process of review for admissions be established which will clearly provide for an investigation of the relevance of each candidate society to the CAS. The protocol on the attached sheet is recommended.

4. Changing the CAS constitution and by-laws to make them consistent with the AAMC constitution and by-laws.

Revised By-laws of the Association of American Medical Colleges were passed by the Assembly in February. Changes

in the By-laws of the AAMC necessitate reviewing the Constitution and By-laws of the CAS. The legal consultants for the AAMC have reviewed the CAS Constitution and By-laws and have recommended changes. These will be available for initial discussion.

5. Designation of delegates to the AAMC Assembly.

Now that the CAS is composed of more than 35 societies, it is essential that a clear procedure for the designation of delegates to the AAMC Assembly be developed. The current By-laws state "Representatives to the Assembly shall be designated from among the constituent societies in annual rotation based upon the date of admission of each society to the CAS."