COUNCIL OF ACADEMIC SOCIETIES
Administrative Board Meeting

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

Time: 10:00 a.m. - 4:00 p.m., Friday, June 4, 1971

		TAB
I.	Consideration of minutes, April 9, 1971 meeting.	J
II.	Action Items:	
	*1. Corporate Responsibility for Graduate Medical Education - Policy statement.	K
	*2. Modified version of new Rules & Regulations for CAS.	L
	*3. Applications for membership in AAMC: 1. Southern Society for Clinical Research 2. American Federation for Clinical Research	M
	*4. Review for final action applications of societies previously placed in deferred status.	N
III.	Discussion Items:	
	1. Resume of research support activities of the AAMC.	O
	2. Further considerations regarding faculty representatives to AAMC.	
	*3. Dues increase for member academic societies of AAMC.	P
	*4. Cost-benefit study of biomedical research.	
IV.	Information Items:	
	1. Report of VA-AAMC Liaison Committee meeting at Arlie House on May 27 - 28, 1971.	
	2. Report of activities of Committee on a House Staff Organization - Dr. Knapp.	
	3. Report on activities of Committee on Financing Programs in Academic Medical Centers - Dr. Cooper.	
	4. Report on planning for AAMC individual membership drive.	
	5. Status report on annual program.	

COMMENTS

Action Items:

1. Corporate Responsibility for Graduate Medical Education - Policy statement. The January 8, 1971 draft of the Committee on Corporate Responsibility for Graduate Medical Education was first considered by the CAS Administrative Board at its February 1971. At that time, it was recommended that the title of the report be changed to "The Implications of Corporate Responsibility for Graduate Medical Education," and that the text be modified so that the report could be used as a basic reference document rather than a policy statement. The Executive Council recommended that a shorter policy statement be developed and circulated to the three Councils for their consideration. A committee consisting of three representatives--one from each Council--and three staff members drew up a short policy statement which has thus far been reviewed by the Administrative Board of COTH, the Administrative Board of the Council of Deans and the regional Council of Deans meetings. The policy statement with the modifications suggested thus far is attached. The Administrative Board should consider the policy statement suggesting any further modifications it desires and then take action to send the statement to the representatives to the Council, inviting their comments and suggested modifications. When these have been returned, a final synthesis of the statement will be made for presentation to all of the Council at the fall meeting. After action by the three Councils, the policy statement will be presented to the Executive Council and the Assembly for final action.

2. Modified version of new Rules & Regulations for CAS. At the April meeting of the Administrative Board a draft of new Rules & Regulations for the Council of Academic Societies was submitted. Modifications were suggested as noted in the minutes of that meeting. These modifications have been incorporated into the Rules & Regulations and are now submitted for a second review. An action forwarding the new Rules & Regulations to CAS representatives for their consideration and ultimate vote at the fall meeting is needed. These Rules & Regulations must finally be approved by the Executive Council.

3. Applications for membership in AAMC. Two applications remain in the Applications-to-be-Considered file. The state of prior deliberations is different for each of these. The Southern Society for Clinical Research was considered by the Administrative Board at two meetings in the fall of 1970. These were the meetings of September 24th and October 10th. The Minutes of those meetings are attached for your information. The recommendation of the Administrative Board that the Southern Society be admitted to the CAS was tabled at the meeting of the Council on October 31, 1970. A decision whe-

ther to pick this application up from the table and resubmit it to the Council or to make a final decision to deny membership is needed.

The American Federation for Clinical Research is a new application which has been in the file since January 12, 1971. An action to reject the application or to issue an invitation to the Society to send a representative or representatives at its own expense to the next Board meeting to discuss the relevance of the Society to the CAS is needed. This is as per the procedures established for admission of societies to the CAS adopted by the Administrative Board at its April 9th meeting. Copies of the fact sheet for the Southern Society and the application form for the AFCR are attached.

4. Review for final action applications of societies previously placed in deferred status. During the past year eight societies have been considered by the Administrative Board and placed in a deferred status. These are:

The American Academy of Dermatology
American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation
American Association for the Study of Liver Diseases
American College of Cardiology
American Society of Plastic and Reconstructive Surgeons, Inc.
Association for Hospital Medical Education
Society of Teachers of Family Medicine.

The information sheets on each of these societies is attached. Action either maintaining their deferred status or moving them into rejected or accepted status is needed for each. The Minutes of the Executive Committee meetings of September 24, 1970 and October 10, 1970 should be consulted for the background on previous actions.

Discussion Items:

3. Dues increase for member academic societies of AAMC. Attached are three schedules for dues increase which would yield varying amounts of dues for support of the activities of the Association. It is believed that a dues increase should be considered at this time. At present member academic societies of the AAMC pay an annual total of $4,700.

A list of the member societies and their present membership numbers is attached.

4. Cost-benefit study of biomedical research. There has been considerable discussion regarding a specific recommendation of the ad hoc Biomedical Research Policy Committee. This recommendation reads as follows:

> "That the public be made aware of the payoffs from basic research, through cost-benefit analyses in which life-saving results are traced to their origins."

The merits and usefullness of such a study at this time has been debated. The Administrative Board has not previously considered this as a formal agenda item.

[Tab I : Minutes]

MINUTES
*ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES
April 9, 1971

O'Hare Airport
Chicago, Illinois

	Committee Members	Staff
Present:	James V. Warren, Chairman (Presiding)	John A. D. Cooper
	Sam L. Clark, Jr.	Mary H. Littlemeyer
	Ronald W. Estabrook	August G. Swanson
	Charles Gregory	
	** Thomas D. Kinney	
	Ernst Knobil	
	William P. Longmire	
	William B. Weil	
	Louis G. Welt	
Absent:	Committee Members	
	Patrick J. Fitzgerald	
	** Jonathan E. Rhoads	

* According to Bylaws of the AAMC adopted by the Assembly on February 13, 1971, the three AAMC Councils are governed by Administrative Boards.
** Ex Officio

I. Adoption of Minutes

The minutes of the CAS Executive Committee meeting held February 11, 1971, were adopted as circulated.

II. Relationship between the CAS and the possible formation of the Organization of Faculty Representatives

Dr. John Cooper presented several ideas on this subject from Dr. William G. Anlyan, who was unable to be present: A need exists for faculty representation within the AAMC, but having 100 institutional representatives would not be helpful and might detract from possible CAS growth. Another item to consider would be cost:benefit ratios in mounting such a program.

Dr. Weil said faculty on some campuses have begun to unionize. This means they will be organized, and they will want representation. He thinks the junior faculty should be represented through the AAMC, and this could be within the CAS structure. Dr. Welt favored faculty representation through some council other than the Council of Academic Societies. Dr. Longmire was concerned by the unwieldly nature the CAS would have if it were expanded in this manner. Dr. Clark suggested the possibility of the Institutional

Academic Society which could be considered for admission in the CAS.

ACTION: It was moved (Weil) and seconded (Welt) that the Administrative Board go on record in favor of the representation in AAMC of institutional faculties. The motion carried with one dissenting vote (Clark).

ACTION: It was moved (Knobil) and seconded (Welt) that the Administrative Baord of the CAS support the formation of a Council of Faculties.

The motion was defeated with four (4) against (Clark, Estabrook, Gregory, and Longmire) and three (3) for (Knobil, Weil, and Welt).

Dr. Gregory pointed out that the faculty are discipline-oriented. A school's faculty council usually consists of representation from all disciplines. No school could get one faculty man to speak for all faculty.

Dr. Kinney reiterated the concern expressed by others that AAMC provide for faculty representation, but he felt that a "Blue Ribbon" group should study the issue. Perhaps such a group would find that such representation would best be served through the Council of Deans, or through the CAS, or with the establishment of a new council. Dr. Longmire supported the idea of a careful study before any recommendation be made.

ACTION: Upon motion (Clark), duly seconded (Kinney), the Administrative Board voted unanimously to advise the AAMC that the issue is too complicated to deal with piecemeal and that a major effort should be made to study it and outline options.

The Administrative Board is not averse to having faculty representation in the CAS and asked that this sentiment accompany the recorded action.

ACTION: Dr. Estabrook offered the following amendment to the above motion: It is the consensus of the Administrative Board that of the possible three alternatives (faculty representation in AAMC (1) through the COD, (2) through the CAS, or (3) through a new council) discussed more appropriate faculty repsentation would be in the CAS, but a blue ribbon committee should be established for further study and deliberation.

The amendment to the motion was defeated, when the Chairman voted to break the 4-4 tie.

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

The problems in having the AAMC February meeting so close to the AAMC Annual Meeting were discussed. From the CAS standpoint, it is inordinately

difficult to plan a program in so short an interval.

Dr. Cooper and Dr. Swanson will look into other possibilities, including exploring with the AMA the possibility of scheduling their Congress in March.

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

The CAS Administrative Board adopted the following procedure for admission of new societies to the CAS:

1. Inquiry from a society is received: Response. A copy of the AAMC Articles of Incorporation and Bylaws, pertinent CAS documents, and a summary letter emphasizing the goals and purposes of the CAS are sent to the society.

2. Society after reviewing the above documents requests membership. Response. Application form is sent and with this letter pointing out the need for clarification of the tax exempt status of the organization.

3. Society returns application and supporting documents.

4. AAMC staff prepares copies and distributes to Administrative Board.

5. Chairman appoints two representatives to conduct investigation and make recommendations.

6. Board (A) rejects application at this point,
(B) issues an invitation to the society, to send, at its expense, a representative or representatives to the next Board meeting to present the case in person.

7. Board summarizes the society's relevance to CAS/AAMC and circularizes CAS Membership.

8. CAS Membership votes at next regular meeting.

V. Considering CAS current applications for membership

ACTION: The motion was made (Longmire) and seconded (Clark) that a moratorium be declared on all application review and action. Dr. Clark subsequently withdrew his second, and Dr. Gregory seconded the motion.

The motion was defeated.

VI. Changing CAS Constitution and Bylaws to be consistent with those of AAMC

The Administrative Board discussed the draft prepared by Dr. Swanson, "Rules & Regulations of the Council of Academic Societies." The only objections voiced were: (Kinney) that on page 1, paragraph 3, after

sentence 1, the Preamble in the current CAS Constitution be inserted; and (Clark) on page 6 that statements be added that the nominees' permission to run be obtained and that the Nominating Committee must meet in person.

NOTE: Administrative Board members are to forward additional changes in this draft to Dr. Swanson, who will present a revised draft for Administrative Board review at the next meeting.

VII. Legislative Activities

During luncheon, Dr. Cooper briefed the Administrative Board on recent developments in legislative activities.

VIII. Changing methods for representation in CAS

The Administrative Board discussed the February 25, 1971, letter from Dr. Sidney W. Nelson, who is CAS representative from the Society of Chairmen of Academic Radiology Departments. Dr. Nelson recommended that the representation from each academic society be increased from two to six and that at least one representative be chosen from the faculty of each medical school. Dr. Nelson's thoughtful letter was warmly received, and Dr. Swanson was instructed to write him to that effect.

There was, however, no consensus that societies which now elect to have only one official representative, when they have been entitled to two, would be in a position to select or sponsor an increased number of representatives. Or, if they did choose to appoint six representatives, there would be no assurance that this would result in increased attendance at meetings or improved communication to the constituent organizations, and, in particular, to their memberships.

IX. Scientific Writing Course

The invitation that CAS sponsor in conjunction with the Annual Meeting the two-day scientific writing course conducted by Dr. Lois DeBakey was declined. The popularity of this course was discussed. The reasons for the declination were that, first, a concerted attempt is being made to compress the AAMC Annual Meeting into fewer days, and, second, that such a course might be more appropriately offered in conjunction with meetings of the disciplinary groups.

X. Corporate Responsibility for Graduate Medical Education

The January 8, 1971, draft prepared by this Committee has been revised and is now entitled, "The Implications of Corporate Responsibility for Graduate Medical Education." The revised document will be distributed to the three AAMC Councils, accompanied by a policy statement to be drafted by a small committee representing the three AAMC Councils.

XI. Designation of Delegates to the AAMC Assembly

The draft "CAS Rules & Regulations," page 7, paragraph 4, covers the designation of delegates to the AAMC Assembly, which becomes the responsibility of the CAS Administrative Board.

XII. Department of Academic Affairs

Dr. Swanson presented a progress report on the development of the Department of Academic Affairs.

1. Staffing. Two new associate directors will join the department July 1, succeeding Drs. Hutton and Stritter respectively: Ayres G. J. E. D'Costa, Ph.D., Associate Director of the Division of Educational Measurement and Research; and Roy K. Jarecky, Ed.D., Associate Director of the Division of Student Affairs. These highly qualified professionals are expected to greatly strengthen the department. Recruiting for the Division of Curriculum and Instruction and for the Office of Biomedical Research Policy, which are to be established, is in progress.

2. Communications. Dr. Estabrook cited a continuing problem with communications within and between constituent societies. The desirability of having CAS Briefs and other memoranda duplicated by constituent societies and forwarded to their members was discussed. Dr. Weil pointed out that most of the small societies' budgets would not permit such mailings. The bulletins of the larger societies may be a resource. This will be explored.

In this connection, AAMC Individual Membership was discussed. Individual Membership costs $20 annually and provides a subscription to the Journal of Medical Education and to the AAMC Bulletin. The Bulletin contains an extensive and comprehensive monthly report of legislative affairs, AAMC activities, and news from the medical schools. Complimentary subscriptions to the medical schools' over 24,000 full-time faculty would be prohibitive.

3. Dues. Annual dues for CAS organizations currently total $4700. Dr. Swanson was asked to prepare options for a revised dues structure to be considered at the next Board meeting.

4. Annual meeting. The CAS Annual Meeting will be on October 29, Friday afternoon. One-half of the program will be a topical meeting on "Evaluation," cosponsored with the Division of Educational Measurement and Research and the Division of Student Affairs. The CAS Annual Business Meeting will occupy the other one-half of this afternoon, or roughly two hours.

XIII. Nominating Committee Meeting

The Nominating Committee met on March 4. The ballot it formed was circulated to the Administrative Board. The ballot, along with biographical material regarding the candidates, will be circulated to CAS voting members prior to the meeting at which the election will occur.

XIV. House Staff Meeting

Dr. Warren had a copy of the program of the House Staff meeting recently held in St. Louis. AAMC sent Dr. Richard Knapp to this meeting. Although Dr. Cooper's name was listed in the program as a sponsor, AAMC did not sponsor the meeting. AAMC has a joint committee of its Councils appointed to deal with the implications of this faction's current direction.

XV. Matching Program

There is a movement afoot to abolish the matching program. Students are very much in favor of the matching program.

ACTION: The motion was made (Longmire), duly seconded, and unanimously passed that the Administrative Board go on on record as supporting continuation of the matching program for graduating medical students for all disciplines.

Dr. Swanson was asked to communicate this action to all CAS members and to the National Intern and Residency Matching Program.

XVI. Future meetings

The next meeting of the CAS Administrative Board will be held in Chicago on June 4.

At this time, no meeting of the CAS Administrative Board is planned in conjunction with the AAMC Annual Meeting in Washington, October 28 - November 1, 1971.

NOTE: Board members who will be absent for extended periods are: Dr. Weil, August 15, 1971 - January 1, 1972; and Dr. Welt, who begins a one-year sabbatical July 1, 1971, at Oxford.

XVII. Adjournment

The meeting was adjourned at 4:00 p.m.

4/14/71
MHL/sl

[Tab K]

THE IMPLICATIONS OF 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 postdoctoral 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. These two organizations, working through the Liaison Committee on Medical Education, have determined to become involved in graduate medical education, initially through careful re-examination of procedures for accreditation of these programs.

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 the focusing of responsibility in the university (2). Because of their growing role in graduate medical education, the constituent academic medical centers of the AAMC authorized this study of the implications of corporate responsibility for graduate medical education.

Definition

Corporate responsibility for graduate medical education is defined as: the assumption by the academic medical center and its faculty of the classic responsibility and authority of an academic institution for all its students and programs in medical education. This implies that the faculty

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

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

of the medical school would collectively assume responsibility for the education of clinical graduate students* (interns, residents, and clinical fellows) in all departments and that the education of these students would 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 fragmentation, are the following:

1. easier implementation of the continuum concept in medical education;

2. providing for graduate education of students with varying degrees of achievement and rates of progress;

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 and facilities of the university;

5. promoting the introduction of greater efficiency and flexibility in the use of faculty and facilities;

6. enhancing the principle of determination over educational programs by the individual universities; 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 pro-

* 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.

cedures 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 almost all American physicians. The evidence for this allegation is all around us, but it is found most importantly in the attitudes and behaviors of those in practice, those who make hospital appointments and those who decide on professional reward systems.

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 specific agencies 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, 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 clinical graduate students are frequently licensed physicians who 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 eligibility for admission to the specialty board examinations are now determined largely by individual boards. Such boards are characteristically 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 appointed by the AMA's Council on Medical Education, and are made up of individuals from the specialty sections of the AMA and the appropriate boards. 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 inevitably and properly will 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. This service chief has 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 be considered for a more formal role in its design

and operation. It has a 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.

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;

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 are now acceptable in terms of the needs of the public, its ambiguities would be tolerable. Before any new arrangement is adopted, 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 has resulted in the evolution of a very complex structure for graduate medical education. It is this complexity which has created demands for a more holistic approach to the total duration and content of medical education. A corporate approach to graduate medical education could help provide this.

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. If corporate responsibility were adopted, the professional schools would have as large a stake in the postdoctoral educational process as they now have in the predoctoral.

Corporate Responsibility

The responsibility which would be assigned to the academic medical center faculties may be enumerated as follows:

1. Determination of educational objectives and goals;
2. Establish policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals;
3. Appointment of faculty;
4. Selection of students;
5. Determination of content, process and length of educational program;
6. Evaluation of each student's progress; and
7. Designation of completion of program and readiness for being admitted to Specialty Board examination.

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

The medical faculty would have a concern for creating an appropriate environment for graduate medical education.

They would be responsible 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 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 their students' achievement of an appropriate educational level and their readiness to take examinations for certification by the appropriate 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 in the university. There would also be greater coordination of educational activity within the clinical faculty. Presumably, there would be more effective integration of various units of the medical center both medical and nonmedical, and this integration could be expected to produce different educational and patient care alignments. Possibly, the medical faculty might develop course-work, a credit system and examinations similar to those now operated for undergraduate education.

These organizational patterns would likely precipitate decisions about which aspects of specialty training should precede and which should follow the M.D. degree. These questions must be faced in any event, and the 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 would 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 issue of advanced and intermediate degrees in medicine is not trivial. Residents now get unimportant pieces of paper from hospitals (certificates of service) and important pieces 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 pattern 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 has 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 significance 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 this implication 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. As far as financing goes, there would be few differences from 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 the local control of the joint medical school-hospital faculty.

The University, Graduate Education, and Nonaffiliated Hospitals

Although the university medical center initally 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 would 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 relationships created might 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 university-directed educational program. All such arrangements for cooperative or integrated efforts would 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 educational programs. These would all eventually work to the advantage of the students, and this result for them must be seen as one of the major benefits expected from the change. Admission to, progress through, and certification of completion of training would become more formal, less casual, and more subject to general university procedures.

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, through direct charges for hospital services. This system is now challenged by many: 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 graduate 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 the 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. The boards would 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 change to corporate responsibility 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 already 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'etre 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 considerations.

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals

The Ad Hoc Committee on Corporate Responsibility for Graduate Medical Education submitted a report to the Councils of the Association at the February 1971 meeting. It was recommended by the Executive Council that the title of the report be modified, indicating that the report was a study of the implications of corporate responsibility for graduate medical education rather than a policy statement. The Executive Council also requested that a brief policy statement be derived from the report and submitted to the Councils for study.

This policy statement was developed by the Committee listed below and is respectfully submitted for study by the Councils of the Association.

Thomas D. Kinney, M.D., Council of Academic Societies
John Parks, M.D., Council of Deans
David Thompson, M.D., Council of Teaching Hospitals
Mr. John M. Danielson, Staff
Marjorie P. Wilson, M.D., Staff
August G. Swanson, M.D., Staff

April 13, 1971

The modifications indicated either by ~~deletions~~ or by additions in *italics* were recommended by the COTH Administrative Board and the Executive Committee of the Executive Council.

April 15, 1971

****

The policy statement set forth below was derived from a report on the "Implications of Corporate Responsibility for Graduate Medical Education". That document should be used for guidance in the development of the assumption of responsibility for graduate medical education by academic medical centers.

~~POLICY STATEMENT ON THE CORPORATE RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION~~

The Association of American Medical Colleges endorses the concept that graduate medical education should become

NORTHEAST COD — POLICY STATEMENT ON THE UNIFIED RESPONSIBILITY OF ACADEMIC MEDICAL CENTERS FOR GRADUATE MEDICAL EDUCATION

SOUTHERN COD — STATEMENT OF GOALS ON THE RESPONSIBILITY OF ACADEMIC MEDICAL CENTERS FOR GRADUATE MEDICAL

a corporate responsibility of the faculties of the academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by *academic* medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment, review curricula and instructional plans for each specific program, arrange for evaluating graduate student progress periodically, and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools. ~~Hospitals with limited graduate programs desiring to continue their educational endeavors, should seek affiliation with an accredited academic medical center.~~

NORTHEAS COD

The Association urges that the Liaison Committee on Medical Education, the Residency Review committees of the AMA, and the several Specialty Boards AND OTHER APPROPRIATE ORGANIZATIONS continue their efforts toward developing procedures which will provide for accrediting an entire institution's graduate medical education program *by one accrediting agency*.

MIDWEST COD

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

~~The development of graduate education curricula and instructional programs should take cognizance of appropriate financing for both the service and educational components of the graduate experience.~~

ORTHEAST OD

IT IS ESSENTIAL THAT ALL RELATED COMPONENTS OF ACADEMIC MEDICAL CENTERS DEVELOP TOGETHER APPROPRIATE FINANCING FOR THE SUPPORT OF EDUCATION, RESEARCH & SERVICE IN THE GRADUATE EXPERIENCE.

IDWEST OD

IT IS ESSENTIAL THAT ALL RELATED COMPONENTS (INCLUDING HOSPITALS) OF ACADEMIC MEDICAL CENTERS DEVELOP TOGETHER APPROPRIATE FINANCING FOR THE PROGRAM COSTS OF GRADUATE MEDICAL EDUCATION.

[Tab 4]

Association of American Medical Colleges
Council of Academic Societies

Introduction

The Association of American Medical Colleges is a corporation organized for the advancement of medical education. The purpose is exclusively educational, scientific and charitable.

The Association membership consists of classes known as (1) Institutional Members, (2) Provisional Institutional Members, (3) Academic Society Members, (4) Teaching Hospital Members, and (5) such other members as provided in the Bylaws of the Association. Institutional Members have the right to vote. Provisional Institutional Members, Academic Society Members, and Teaching Hospital Members have the right to vote to the extent and in the manner provided by the Bylaws of the Association. All voting members are organizations with a tax exempt status ~~described in Section 501 (c) 3 of the Internal Revenue Code of 1954 or other Codes~~ as set forth in Section I of the Bylaws of the Association. The member Academic Societies of the Association form the Council of Academic Societies. This Council is governed by the Rules and Regulations set forth below.

The Council of Academic Societies was formed in order to provide for greater faculty participation in the affairs of the Association of American Medical Colleges. The specific objectives of the Council are to serve as a forum

and as an expanded medium for communication between the Association and the faculties of the schools of medicine. In this forum, enhanced faculty participation in the formulation of national policies to provide for the whole span of medical education is provided. Mechanisms of communication include election of representatives to serve on the Executive Council of the Association of American Medical Colleges as set forth in theBylaws of the Association.

Rules and Regulations Of The Council of Academic Societies

Section I. Members

1. Academic Societies active in the United States in the professional fields of medicine and biomedical sciences which have special interests in advancing medical education may be nominated for election to membership in the Association of American Medical Colleges by a two-thirds vote of the Society Representatives at a duly constituted meeting of the Council of Academic Societies, provided that notice of the proposed nomination shall have been given to the Representatives of the member Societies at least thirty (30) days in advance of the meeting. The names of Societies so nominated shall be recommended to the Executive Council of the Association of American Medical Colleges for election to membership therein by the Assembly of the Association.

2. Individuals with a special competence or interest in advancing medical education may be nominated by the Council for membership in the Association of American Medical

Colleges using the same procedure as set forth above for nomination of member Societies. Individuals so elected to membership in the Association of American Medical Colleges shall be members-at-large of the Council of Academic Societies.

3. Resignation or revocation of membership. Resignation or revocation of membership in the Council of Academic Societies shall be in accordance with the Bylaws of the Association of American Medical Colleges, and no society or individual who is not a member of the Association of American Medical Colleges shall be a member or member-at-large of the Council of Academic Societies.

Section II. Representatives

1. The Council of Academic Societies shall consist of no more than two representatives from each member Academic Society of the Association of American Medical Colleges. These representatives shall be designated by each member Society for a term of two years; provided, however, no representatives shall serve more than four (4) consecutive terms. The Secretary shall inform each member Society one year in advance of the expiration of the term of its representatives, asking for the names of the representatives for the subsequent term.

2. Voting. Each representative of a member Academic Society shall have one (1) vote in the Council. Members-at-large shall have no vote.

Section III. Administrative Board

1. The Council of Academic Societies shall be governed by an Administrative Board which shall be composed of a Chairman, Chairman-Elect, a Secretary and six other representatives of member Academic Societies. Three of said six representatives shall be elected by written ballot at each annual meeting of the Council of Academic Societies, and each such representative shall serve for a term of two years or until his successor is elected and installed. Representatives to the Administrative Board may succeed themselves for two additional terms.

2. The Administrative Board shall meet at least ~~once~~ *twice* each year at the time and place of the ~~annual~~ meetings of the Council of Academic Societies. ~~held in connection with the annual meeting of the Association of American Medical Colleges, and~~ The Administrative Board may meet at any other time and place upon call of the Chairman, provided ten (10) days written notice thereof has been given.

3. The Administrative Board shall recommend to the Nominating Committee of the Association nominees for positions on the Executive Council of the Association. The Chairman-Elect shall be one (1) nominee, and the remainder shall be chosen from members of the Administrative Board, chosen so as to present a balanced representation between societies primarily concerned with preclinical disciplines and societies primarily concerned with clinical disciplines.

4. Individuals elected as members of the executive Council of the Association of American Medical Colleges representing the Council of Academic Societies may hold their membership in the Council of Academic Societies, ex officio, even though they may be succeeded by new representatives from their constituent organizations.

Section IV. Officers

1. The officers of the administrative Board shall be a Chairman, a Chairman-Elect, and a Secretary, and shall be elected at the annual meeting of the Council of Academic Societies. The Chairman and Chairman-Elect shall serve for a term of one (1) year, or until their respective successors are elected and qualified. The Secretary shall serve for a term of two (2) years but may not serve for more than two (2) years following the expiration of his term as a representative of a member society. Officers shall begin their terms immediately following the annual meeting of the Council at which they are elected.

2. Duties of the Chairman. The Chairman shall be the chief administrative officer of the Council and shall preside at all meetings. He shall serve as Chairman of the Administrative Board and shall be an ex officio member of all committees. He shall have primary responsibility for arranging the agenda of meetings, conducting the business of the Council, and carrying out policies of the Council of Academic Societies determined during meetings of the Council. The Chairman shall

from time to time inform and advise officers of member academic societies of the programs and activities of the Council of Academic Societies.

3. Duties of the Chairman-Elect. The Chairman-Elect shall act as a Vice-Chairman and assume the duties of the Chairman whenever the latter is absent or unable to act. He shall be an ex officio member of all committees, except that on nominations; and he shall succeed to the office of Chairman, upon the expiration of his term as Chairman-Elect.

4. Duties of the Secretary. The Secretary shall be responsible for keeping the minutes of meetings, a roster of members, sending out notices of meetings, and informing members of the business of the Council.

Section V. Committees

1. There shall be a Nominating Committee of seven (7) members. Said Committee will be chosen by mail ballot. A ballot listing 14 representatives will be prepared by the Administrative Board and sent to all representatives to the Council. Seven (7) names shall be selected from the list by each representative and submitted to the Secretary. The seven (7) representatives receiving the largest number of votes will constitute the Nominating Committee, except that no member society shall have more than one (1) representative on the Nominating Committee.

The Committee shall *meet in person and* submit each year to the secretary forty-five (45) days prior to the annual meeting of the Council of Academic Societies the names of two (2) candidates for each office to be filled. *The chairman of the committee will verify in advance that the nominees are willing to serve.* Election of officers shall be by majority vote at the annual meeting of the Council of Academic Societies.

2. The chairman of the Council of Academic Societies may from time to time appoint the chairmen and members of standing or ad hoc committees to advise, assist and carry out the management and operations of the Council of Academic Societies; provided, however, the Chairman shall remain responsible for all action taken by any such committee. Membership on committees will end with the expiration of the term of the representative to the Council. The Chairman of the Council of Academic Societies may appoint any representative to the Council to fill vacancies on any committee, including the Nominating Committee. Members of ad hoc committees may be selected from the academic community at large.

Section VI. Meetings

1. The Council of Academic Societies shall meet during or within two (2) days after the annual meeting of the Association of American Medical Colleges for the purpose of electing officers and transacting other business which may come before it. The Council shall meet regularly at least one

additional time each year, and it may meet for special purposes at other times determined by the Administrative Board, provided the purpose of such meetings be stated in the notice thereof. Written notice of meetings shall be given by the Secretary at least 30 days prior to the date thereof, and meetings shall be held in conjunction with other activities of the Association of American Medical Colleges whenever possible.

2. Any question which five (5) or more representatives desire to have placed on the agenda of a meeting shall be considered at that meeting.

3. A quorum shall consist of 15 representatives or 25 percent (25%) of *representatives to* the Council, whichever is the larger.

4. The Administrative Board shall designate the member societies to be delegates to the Assembly of the Association. These member society delegates will serve for a period ending with the conclusion of the Assembly after the time of being so nominated; provided, however, that the delegates so named shall be approved by majority vote of the Council of Academic Societies and additional nomination of delegates to the Assembly may be made at the meeting at which those named by the Administrative Board are approved.

Section VII. General Provisions

1. The Council may not incur debts or enter into commitments by accepting restricted funds or otherwise, which could in any manner become obligations of the Association of American Medical Colleges, without first obtaining specific authorization of the Executive Council or President of the Associa-

tion. Member academic societies shall be responsible for costs and expenses incurred by their respective representatives to the Council of Academic Societies.

2. Any conflict between the Articles of Incorporation or the Bylaws of the Association of American Medical Colleges and these Rules and Regulations shall be resolved in accordance with the provisions of said Articles or Bylaws, as the case may be; and these Rules and Regulations shall whenever possible be applied, interpreted, or construed in a manner consistent with said Articles and Bylaws.

3. Amendments to these Rules and Regulations may be made at any meeting of the Council of Academic Societies, provided at least 30 days written notice thereof has been given to members entitled to vote by a two-thirds vote of those voting members present. Any such amendment shall be effective only upon subsequent approval by the Executive Council.

4. Any notice required to be given to any representative or officer may be waived in writing before or after the meeting for which such notice is required.

[Tab M]

(1-C)

1. Name of Society

   Southern Society for Clinical Investigation

2. Purpose

   To encourage research in the various medical sciences and to establish a forum from which new ideas can be promulgated to the medical profession.

3. Membership

   Any doctor of medicine, doctor of philosophy or doctor of science who has accomplished meritorious research in a branch of the medical sciences related to clinical medicine, and who resides within the territorial limits of the Society and enjoys an unimpeachable reputation in his profession, shall be eligible for membership.

4. Number of members

   165

5. Constitution and bylaws available

6. Minutes from 24th Annual Meeting held on 1/30/70 available

7. Organized

   1946 (as Southern Society for Clinical Research)

8. Recommendation-

   9/24/70 - Executive Committee approved, then reconsidered
   10/10/70 - Executive Committee reapproved
   10/31/70 - CAS Membership Tabled Application

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Mary H. Littlemeyer

NAME OF SOCIETY: AMERICAN FEDERATION FOR CLINICAL RESEARCH

MAILING ADDRESS: 6900 Grove Road Thorofare, New Jersey 08086

PURPOSE: See attached sheet

MEMBERSHIP CRITERIA: See attached sheet

NUMBER OF MEMBERS: 6122

DATE ORGANIZED: 1940

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

May 1969 1. Constitution & Bylaws

May 1970 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

THE AMERICAN FEDERATION FOR CLINICAL RESEARCH

The purpose of the organization:

> The purposes for which the corporation is organized are educational and scientific, including for such purposes the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) and contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law). In furtherance of but not to exceed the foregoing purposes, the corporation is empowered to promote and encourage original research in clinical and laboratory medicine and to welcome as members, and provide an accessible forum for, young persons engaged in such research.

Criteria for Membership:

There shall be three types of members ---

A. Regular Members
B. Senior Members
C. Corporate Members

Regular Members. Any person under the age of 41 whether a resident of the United States or not, who has completed and published a meritorious investigation in any field related to medicine shall be eligible to apply for Regular Membership.

Senior Members. Upon reaching the age of 41, A Regular Member shall automatically be transferred to Senior Membership, effective as of the first day of the calendar year following his 41st birthday. In addition, any person over the age 41 who has completed and published a meritorious investigation in any field related to medicine and who is actively stimulating younger persons to pursue similar investigations shall be eligible to apply for Senior Membership.

Corporate Members. Any corporation or foundation interested in the purposes of the AFCR may, upon invitation and the payment of the prescribed dues, become a Corporate Member of the AFCR. Such invitation shall be extended by the Secretary on the direction of the Council. The Council shall establish the classification of Corporate Memberships.

QUESTIONNAIRE FOR TAX STATUS

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

   x YES ____ NO

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

   501 3C

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

   x a. Approved by IRS

   ____ b. Denied by IRS

   ____ c. Pending IRS determination

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

   see attached

(Completed by - please sign)
Charles B. Slack, Executive Secretary
January 8, 1970 1971
(Date)

Rec'd 1-12-71 SMK

MINUTES
EXECUTIVE COMMITTEE
COUNCIL OF ACADEMIC SOCIETIES
September 24, 1970

AAMC Headquarters
Washington, D.C.

Present: Committee Members

D. C. Tosteson, Chairman (Presiding)
Sam L. Clark, Jr.
Harry A. Feldman
Patrick J. Fitzgerald
Charles Gregory
Thomas D. Kinney
* Jonathan E. Rhoads
James V. Warren
William B. Weil, Jr.

Staff

John A. D. Cooper
Mary H. Littlemeyer
Marjorie P. Wilson
Linda Warnick

* Present for a portion of the meeting

The meeting was called to order.

The minutes of the last meeting were adopted as circulated.

I. President's Report

AAMC President John A. D. Cooper reviewed with the Executive Committee the current organizational structure in development. The new plan is designed to enable AAMC to operate as a leadership organization rather than as one that continues merely to respond to new and ongoing trends.

Staff additions representing new expertise in key roles were described. A head for the Department of Academic Affairs is still being sought.

Dr. Cooper emphasized the interrelationships among the three AAMC Councils and among AAMC staff in the overall programs of the Association. AAMC resources are available to all Councils.

A newly established ad hoc Committee on the Financing of Medical Education draws representation from three other AAMC ad hoc committees: Biomedical Research Policy, Expansion of Medical Education, and Medicare. Such an arrangement, Dr. Cooper said, leads to a mobile organization through its flexibility. Fewer standing committees, therefore, will result, with an increase in ad hoc committees and task forces.

Since projects are authorized in the Executive Council, the three Councils need to be very critical of whom they nominate to representation.

The Association has legal counsel who is an expert in this area reviewing the Bylaws of the AAMC and those of its three Councils. The CAS Bylaws are inconsistent and on some points incompatible with AAMC Bylaws. To illustrate, CAS dues can only be revised by the Assembly of the Association.

Among concerns voiced by members of the Executive Committee were the following: the need to involve in the CAS "average" faculty members from CAS constituent societies and the need to maintain both the identity and the momentum that CAS has gained during its developmental years and not to submerge it in the AAMC organization vis-a-vis the old "Deans' Club."

II. Mechanism for Election of Societies to CAS Membership

The Executive Committee reviewed the summary under Tab B regarding its action on June 12, 1970, to recommend a revision in the mechanism for election of societies to CAS membership. In view of the finding that the Executive Committee was not, under the CAS Constitution, empowered to do this, it took the following action:

ACTION: Upon motion, duly seconded, the Executive Committee voted to sustain the present procedure for the election of societies to CAS membership.

III. Definition of Criteria for Assignment of Societies to Panels

In connection with this topic, the Committee reviewed the assignment of current CAS members to panels under Tab D. This summary of members assigned to Professorial and Professional Societies was prepared by Dr. Cheves Smythe according to information he had available at the first of the year but not according to explicit criteria available to the Committee at this time. Dr. Weil pointed out that the American Pediatric Society (254 members) was incorrectly listed under Professional Societies, whereas it should be under Professorial Societies.

Dr. Rhoads explained that the decision for inclusion of the colleges in the CAS was based on the desire to draw representation from continuing education. Dr. Rhoads proposed consideration of the following three Panels:

1. Panel of Professors
2. Panel of Professional Societies
3. Panel of Postgraduate Education

Dr. Warren presented an alternative suggestion for the three panels: Professorial; Research and Graduate Education; and Postgraduate (the colleges).

Dr. Gregory and Dr. Tosteson maintained that the CAS was founded to truly represent academic medicine; that the goal has not been accomplished but that the CAS is moving in that direction. Admission of young turks, and those with primary interest in research, or in graduate education is a step that has not yet been taken. Dr. Tosteson suggested deferring action on the colleges and emphasizing a more effective representation within the faculty.

ACTION: Dr. Clark moved that the action taken by the Executive Committee on June 12, 1970, as recorded in the minutes on page 5, to approve the applications of the seven organizations listed for membership, be reconsidered. The motion was seconded by Dr. Fitzgerald. The motion failed.

In the discussion of the previous action, Dr. Cooper pointed out that any reorganization of the Council of Academic Societies must be approved by the Executive Council. Any Bylaws change, which would include a "Panel of Colleges" or any other modification would not be effective until approved by the Executive Council. Ratification by the Executive Council would not be possible before its December meeting.

Drs. Rhoads and Weil supported the inclusion of the colleges.

ACTION: Dr. Rhoads moved that the CAS Bylaws Committee be reactivated to reconsider Article 6, adding colleges with a definition and including a mechanism for representation, for consideration by the Executive Committee in Los Angeles. This motion was seconded and carried unanimously.

IV. Consideration of Applications for Membership

ACTION: The motion was made and duly seconded that applications for membership be considered later in the agenda. The motion failed.

A total of seven applications for membership had been approved by the CAS Executive Committee on June 12, 1970. Five of these were "colleges." For this reason, a number of applications previously refused because the organizations were "colleges" were reactivated; two applications tabled at the June meeting were reconsidered; and five new applications were presented for consideration, making a total of 14 applications for action before the CAS Executive Committee on September 24.

ACTION: The action of the CAS Executive Committee taken on September 24, 1970, applications for membership is summarized on the following page.

APPROVED (Panel)

1. American Academy of Allergy (3)
2. Plastic Surgery Research Council (2)
3. Assn. for Academic Surgery (2)
* 4. Am. Gastroenterological Assn. (2)
* 5. Am. Assn. for Thoracic Surgery (2)
6. The Endocrine Society (2)
7. Southern Society for Clinical Investigation (2)

DEFERRED

1. Society of Teachers of Family Med.
** 2. Am. College of Cardiology
** 3. Am. Academy of Dermatology
** 4. Am. Soc. of Plastic & Reconstructive Surgeons, Inc.
** 5. Am. Academy of Physical Med. & Rehabilitation
6. Assn. for Hospital Medical Education
** 7. Am. Academy of Neurology

* Approved pending investigation of reason why CAS Executive Committee approval had been withdrawn. Record shows that these organizations were approved by the CAS Executive Committee and narrowly won approval by the CAS Membership on November 2, 1969. Upon recommendation of the CAS Executive Committee, on December 18, 1969, the Executive Council remanded applications of the American Association for Thoracic Surgery and the American Gastroenterological Association to the Executive Committee. No further action was taken.

** Application deferred pending report of the Chairman's ad hoc committee to investigate the colleges in existence to decide which is most prominent in the field to advise the Executive Committee.

(continued)

The Executive Committee engaged in a vigorous discussion about the approval of the Southern Society for Clinical Investigation. The vote was tied with four for and four against; the Chairman broke the tie favoring approval. Dr. Rhoads thought that the Committee ought not to consider applications from regional societies. Dr. Weil shared this sentiment. Both felt that this was a policy issue. The other camp held that the application should be considered based on the single merits of the group applying. This organization has been very actively interested in the efforts of the Committee on Biomedical Research Policy and is soliciting contributions to aid in its support. This brought up the question of the overriding purpose for which the Council of Academic Societies was founded, as delineated in its Constitution:

COUNCIL OF ACADEMIC SOCIETIES
OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

CONSTITUTION

Preamble

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

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

Article 1

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

Article 2. Part 1—Constituent Societies

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

At this point the meeting was adjourned for lunch, which was served in the Conference Room. The first item of business following lunch was the introduction of the following motion by Dr. Gregory.

ACTION: It was moved that all applications acted upon by the Committee in the morning be reconsidered, not retroactive to past meetings, and that, at the same time, guidelines be produced for decisions regarding the future election of applicants. The motion was seconded by Dr. Weil.

Dr. Gregory added that policy has been decided regarding the selection of regional organizations and colleges in the absence of criteria for membership. Dr. Kinney supported the idea of soliciting members in areas in which the CAS is weak. Dr. Fitzgerald thought that the Committee needed better cri-

teria for admissions and more study of the applications. Dr. Kinney advocated a full day's meeting within the next two-three weeks devoted to the structure and function of the Council of Academic Societies. Another voice indicating the need for such a meeting was that of Dr. Warren. Dr. Clark supported Dr. Kinney's concern but added that decisions had been made before Dr. Weil and Dr. Gregory came to the CAS Executive Committee, although this did not mean that such decisions should not be reconsidered.

ACTION: It was moved, and duly seconded, that the Executive Committee reconsider the morning's actions only with regard to constituent elections and that guidelines be produced regarding future criteria for election of applicants, not including the election of colleges elected at the previous meeting whose election must stand. The motion carried with three for, three against, one abstaining, and the Chairman voting in favor of the motion to break the tie. At this point, Dr. Rhoads had left the meeting.

(Motion restated)

Dr. Clark then offered the following motion, which was not seconded:

MOTION: That the Executive Committee adopt an open admissions policy that requires that the applicant organization further the aims of the CAS, that it have an interest in medical education, and which, in the judgment of the Executive Committee, satisfies minimal standards.

Dr. Clark said the Committee should accept the idea of open membership and develop minimal standards. Dr. Clark then presented the following motion:

MOTION: That the CAS Executive Committee agree on a policy of relatively open admission, with minimum standards developed, subject to review by the Executive Committee.

Dr. Clark withdrew the above motion, and offered the following motion:

MOTION: That the Executive Committee agree that there should be no policy regarding the number of societies admitted to the Council of Academic Societies. There was no second to the motion.

Dr. Tosteson summarized the issues as follows:

1. Representation from the Panels in the Assembly & Executive Council
2. Representation from the Panels in the CAS Executive Committee
3. Number of representatives per society
4. Independence of Panels in regard to:
   (a) Officers
   (b) Projects
   (c) Money

Dr. Gregory presented the following proposal for representation:

Officers--Alt. Basic Science/Clinical Sciences
Executive Committee--Equity Basic Science/Clinical Sciences
AAMC Committee Representatives--Equity Basic Science/Clinical Sciences
Categories of Members (with two representatives per organization)--
Professorial)
Professional) One organization per discipline or specialty
Colleges)

Dr. Kinney thinks that the Executive Committee should stop to think what is best for the CAS and what will most clearly represent the faculty.

Dr. Cooper pointed out that when groups have interests that diverge from the medical center interests, it is more difficult to get a consensus.

Dr. Weil's suggestion for organization was the following:

Representation	Orientation
3	Academic (Primarily)
2	Mixed (Both Academic and Practice)
1	Practice (Primarily)

The above scheme emphasizes that the Council of Academic Societies is faculty-oriented.

Dr. Warren suggested that one organization per specialty or discipline of medical education might be indicated, with associate membership of other groups.

Dr. Clark favored Dr. Kinney's suggestion that action on the colleges be suspended.

Dr. Gregory suggested that the colleges be left in but that an Associate Membership be established in the Bylaws.

A discussion ensued regarding developing a "third force" for medicine. Dr. Tosteson said that an ecumenical voice in academic medicine is quite different from a third force in medicine. The question has to be asked: Will the addition of societies in the past year accelerate the trend toward an ecumenical voice in academic medicine within the AAMC? Dr. Clark added his doubts that the colleges would enhance the purposes of the medical school faculty through the CAS. Dr. Kinney then suggested that the Executive Committee approve the American College of Physicians, the American College of Surgeons, and the American Academy of Pediatrics as regular societies and drop the panel idea to see what happens.

The Chairman named a new CAS Committee on Bylaws. It consists of Dr. Clark, as Chairman, and Drs. Fitzgerald, Gregory, Warren, and Weil. The Committee is charged to prepare possible revisions of Article 6 for consideration by the Executive Committee.

ACTION: Dr. Kinney moved that the actions taken regarding membership on June 12, 1970, be reconsidered. The motion was duly seconded and carried with two voting against the motion.*

V. Consideration of Dues

No change in dues for CAS members will be recommended at this time.

VI. Next Meeting

A special meeting of the Executive Committee was called to convene on October 10 at 8:30 a.m. in the Conference Room of the AAMC Headquarters.

VII. Adjournment

The meeting was adjourned at 4:30 p.m.

* Applications that had been approved by the Executive Committee June 12, 1970, were:

1. American Academy of Ophthalmology & Otolaryngology
2. American Academy of Pediatrics
3. American College of Obstetricians & Gynecologists
4. American College of Physicians
5. American College of Surgeons
6. American Society for Clinical Investigation, Inc.
7. Society for Pediatric Research

MINUTES
EXECUTIVE COMMITTEE
COUNCIL OF ACADEMIC SOCIETIES
October 10, 1970

AAMC Headquarters
Washington, D.C.

Present: Committee Members

D. C. Tosteson, Chairman (Presiding)
Sam L. Clark, Jr.
Patrick J. Fitzgerald
Charles Gregory
Thomas D. Kinney
James V. Warren

Staff

John A. D. Cooper
Mary H. Littlemeyer
Linda Warnick

Absent: Harry A. Feldman
Jonathan E. Rhoads
William B. Weil, Jr.

The meeting was called to order.

The minutes of the last meeting were adopted as circulated.

1. Report of the CAS Nominating Committee

The CAS Nominating Committee elected this year consisted of Dr. Charles A. Janeway (Chairman), and Drs. Sam L. Clark, Jr., Charles F. Gregory, Thomas D. Kinney, Eugene A. Stead, Jr., D. C. Tosteson, and Louis G. Welt (Members). Four of these individuals, also members of the CAS Executive Committee, were present. There was considerable discussion about the limited effectiveness that the Nominating Committee encountered again this year. To eliminate these recurring difficulties, a proposed revision in the Bylaw (Article 2, Section 2) governing the method for the establishment of the Nominating Committee had been approved by the Executive Committee on June 12.

Dr. Tosteson reviewed the tenure of office of the Executive Committee as presently constituted: five of the eight members would rotate off in the fall of 1971. This does not include the Secretary-Treasurer, who is elected annually. After a careful consideration of this dilemma, the Executive Committee took the following action:

ACTION: Upon motion made by Dr. Sam Clark and seconded by Dr. Thomas Kinney, the Executive Committee unanimously approved the assignment of terms of office to the Executive Committee to end in 1970 to Drs. Clark, Kinney, and Rhoads; and terms of office to the Executive Committee to end in 1971 to Drs. Fitzgerald,

ACTION:
(Cont.) Gregory, and Weil.

Hereinafter, Executive Council Membership as a CAS representative will not require simultaneous membership on the Executive Committee of the Council of Academic Societies. Representatives from the Council of Academic Societies to the Executive Council shall be ex officio members of the Executive Committee of the Council of Academic Societies.

Dr. Tosteson reviewed the slate that has been drawn up for election by the CAS Membership at the Annual Business Meeting, October 31. It consists of the following:

Chairman of the Assembly	One Name
CAS Chairman	One Name
CAS Chairman-Elect	Two Names
CAS Secretary-Treasurer	One Name
CAS Executive Committee	
Two-year Terms	Three Positions Open--Six Names
One-year Term	One Position Open to Fill Unexpired Term--Two Names

The Chairman-Elect will serve as the new CAS Representative to the AAMC Executive Council.

A summary of terms in office of the Executive Committee reflecting the action above described appears on the attachment to these minutes.

II. Report of the Bylaws Committee

As charged by the Executive Committee on September 24, the newly constituted CAS Bylaws Committee drafted options for a revised Article 6 to the Bylaws (to replace that reviewed on September 24) for proposed adoption by the Membership on October 31. These options were distributed by the Chairman, Dr. Sam L. Clark, Jr., to the Executive Committee prior to the meeting. Dr. Clark summarized the intent of the three options as follows:

Option 1 maintains the present system without panels, but adds the colleges as associate members who may not vote or hold office.

Option 2 creates two panels as we did before, but does not include the colleges at all.

Option 3 consists of the two previously described panels, plus a third panel for colleges, and formulas for unbalanced representation of panels in the various activities of the Council of Academic Societies.

In addition, Dr. Gregory had written to Dr. Clark offering other alternatives. His letter was reproduced for the Committee and is a part of the Archives of these minutes.

Although the Committee reached no consensus on the matter, a number of

issues were surfaced:

1. What is "academic" medicine? If this is the continuum espoused by Coggeshall and others, does this mean a broadened role for the Council of Academic Societies, to include continuing education, over that delineated in its Constitution?

2. Does the Council of Academic Societies represent academic medicine or medicine? Dr. Fitzgerald predicted that the CAS would lose faculty participation in direct proportion to the admission of the colleges and academies.

3. What purpose would be served in the creation of panels? An individual's orientation is first to his discipline or specialty. The Council of Academic Societies has been created to provide a forum to bring together faculties of the schools of medicine. To create separate panels will emphasize the stratification that already characterizes the group that the CAS has been attempting to unite.

4. Should the organizations be the members of the CAS, rather than the individuals designated by them, as is now the case?

Finally, it was agreed that expansion of the CAS is a matter for AAMC consideration. Dr. Cooper suggested that this might be a major agenda item for the AAMC December retreat.

After much discussion and debate over the panel options, the following action was taken:

ACTION: Upon motion, duly seconded, the Executive Committee agreed in principle to admit colleges to CAS membership, leaving unspecified their representation. The motion carried with four for and one against (Dr. Fitzgerald).

Dr. Tosteson spoke against the panel concept and introduced a fourth option: a simple Bylaw that attempts to assure that the two represnetatives from any organization be full-time members of the faculties of schools of medicine or comparable institutions of medicine or research. Then the question of defining "full-time" faculty arose. Dr. Warren favored either no panels or two panels, one for the full-time faculty and the second for all others. Dr. Clark said he was convinced that the panel idea should not be pursued and favored no change.

The following motion was offered by Dr. Warren:

MOTION: To discontinue the panelization process, prepare a statement of questions to be presented for long-range consideration, and reconsider applications for membership. There was no second to the motion.

At this point, the following summary of options was made:

Option 1. Proceed to enlarge the CAS by recommending additional groups including the colleges, with no other changes;

Option 2. Adopt a panel system of two panels--one professorial and the second all others; or

Option 3. Remain with the basic unity of the CAS but adopt a policy that would assure that organizations contribute individuals who are primarily academicians.

ACTION: Upon motion made by Dr. Clark, and seconded by Dr. Warren, the Executive Committee voted unanimously to rescind its June 12 recommendation of Bylaws Article 6.

III. Consideration of Applications for Membership

ACTION: It was moved by Dr. Warren, and seconded by Dr. Kinney, that applications for membership of the seven societies approved by the Executive Committee on June 12, and as listed on page 8 of the September 24, 1970 Minutes, be reapproved.

Dr. Gregory observed that the recommendations had again been made in the absence of stated guidelines. Dr. Clark indicated that he was perhaps not as uncomfortable in the absence of explicit criteria as he would be with them. Dr. [illegible] indicated that more than this discussion what was needed was a provision to [illegible] that the individuals that represent the groups come from academic medicine. Dr. Gregory then offered an amendment to the motion.

AMENDMENT TO THE MOTION: To reaffirm the motion with a temporary freeze on the admission of additional societies. Dr. Fitzgerald seconded the amendment to the motion. The amendment to the motion was not accepted and was withdrawn.

ACTION: (Cont.) The motion carried with four for and one against (Dr. Fitzgerald).

Applications thereby approved for membership are:

1. American Academy of Ophthalmology & Otolaryngology
2. American Academy of Pediatrics
3. American College of Obstetricians & Gynecologists
4. American College of Physicians
5. American College of Surgeons
6. American Society for Clinical Investigation, Inc.
7. Society for Pediatric Research

MOTION: Dr. Clark made a motion to approve the application of the Association of Academic Surgery. The motion was duly seconded.

Dr. Tosteson pointed out Dr. Gregory's earlier recommendation that each discipline or specialty have only one representative society and that the CAS

already has three members that represent surgery. Dr. Gregory added that the organizations represent "general surgery," and no one can define what that encompasses.

Dr. Clark subsequently withdrew the motion.

MOTION: Dr. Gregory moved that the Executive Committee temporarily defer consideration of all pending applications. The motion was seconded but was defeated.

ACTION: Dr. Clark made a motion to approve the application of the Association of Academic Surgery. The motion was seconded by Dr. Kinney and was unanimously approved.

ACTION: Dr. Warren moved approval of the remaining six applications approved on September 24 (as listed on page 4 of the minutes). The motion was duly seconded and carried with one abstaining (Dr. Fitzgerald).

The applications thereby approved are:

1. American Academy of Allergy
2. Plastic Surgery Research Council
3. American Gastroenterological Association
4. American Association for Thoracic Surgery
5. The Endocrine Society
6. Southern Society for Clinical Investigation

MOTION: Dr. Gregory then moved that all applications deferred on September 24 (as listed on page 4 of the minutes) be approved. The motion failed for lack of a second.

The application for membership of the American Association for the Study of Liver Diseases was next considered.

ACTION: It was moved, duly seconded, and unanimously carried that the new application from the American Association for the Study of Liver Diseases be deferred.

Applications deferred, then subsequently reconsidered, on September 24, were again considered.

ACTION: It was moved, seconded, and unanimously carried that the following applications, deferred on September 24, then reconsidered on the same day, be again deferred:

1. American Academy of Dermatology
2. American Academy of Neurology
3. American Academy of Physical Medicine & Rehabilitation
4. American College of Cardiology
5. American Society of Plastic and Reconstructive Surgeons, Inc.
6. Association for Hospital Medical Education
7. Society of Teachers of Family Medicine

SUMMARY OF ACTIONS ON ALL APPLICATIONS:

Applications approved.--The following applications were approved and, in compliance with the Bylaws of the CAS, staff were instructed to send to the Membership in a memorandum dated October 1, the following recommendations for membership:

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
14. Southern Society for Clinical Investigation

Applications deferred.--The following applications were deferred:

1. American Academy of Dermatology
2. American Academy of Neurology
3. American Academy of Physical Medicine & Rehabilitation
4. American Association for the Study of Liver Diseases
5. American College of Cardiology
6. American Society of Plastic and Reconstructive Surgeons, Inc.
7. Association for Hospital Medical Education
8. Society of Teachers of Family Medicine

Dissemination of information.--Staff were instructed not to release any information regarding the status of any new application. Any inquiries that relate to this issue are to be referred to the Chairman of the CAS Executive Committee.

IV. Consideration of CAS Voting Representatives to the AAMC Assembly

In the event that a quorum is not declared present in an AAMC Assembly, the roll must be called. For this purpose, the Executive Committee was asked for a list of its Voting Representatives to the AAMC Assembly. The CAS, however, has not designated voting members and could not comply with this request. This will be handled informally during the business meeting on October 31.

ACTION: Dr. Kinney made a motion that when membership in the CAS exceeds 35 members, one of which each now has one vote in the Assembly, the first 35 members elected to the CAS have the option of one seat each. Then, in rotation as places occur, the next organization will be invited to name a Voting Representative. The motion was seconded and carried.

The Bylaws Committee was designated to prepare resolution on the matter of Voting Representation in the Assembly. (NOTE: This was subsequently done and appears as Article 6 of the Bylaws being proposed for adoption on October 31, 1970).

V. Carnegie Report

The President distributed to the Executive Committee copies of Higher Education and the Nation's Health: Policies for Medical and Dental Education--A Special Report and Recommendations by The Carnegie Commission on Higher Education. 130 pp. October 1970. The Report will be released to the public October 29 at the AAMC Annual Meeting in Los Angeles. Copies were later distributed to official representatives of the Council of Academic Societies, and the CAS Committee on Biomedical Research Policy. The Committee did not feel that it could, in good conscience, endorse the Report. In specific situations, however, the Committee noted recommendations that were consonant with those of the AAMC.

VI. Annual Meeting

The Committee reviewed the schedule of activities previously distributed. A few changes were made, and a revised calendar was mailed to the Committee on October 16.

The Committee received as information the promotional materials regarding the Council of Academic Societies that went forward to almost 300 CAS members on October 9. Included was an informative summary of the year's activities; a list of key committees, both AAMC and CAS; and a synopsis of the CAS program to be held in Los Angeles.

VII. Consideration of February, 1971 Meeting

The CAS Executive Committee wishes to consider holding an all-day meeting on Friday, February 12, at the Palmer House in Chicago.

A short business meeting might include:

Family Practice
Medicare
Third-Party Payers vs. Teaching Hospitals
Committee Reports

An ad hoc Committee will do some preliminary planning on Thursday, October 29, with lunch in Dr. Warren's suite at the Biltmore. Joining Dr. Warren on this ad hoc Committee are Drs. Clark, Fitzgerald, and Weil.

Tentative plans for the February meeting are:

Feb. 11 (Thurs.)	8 pm	CAS Executive Committee
Feb. 12 (Fri.)	all day	CAS Membership
Feb. 13 (Sat.)	am	AAMC Executive Council
	pm	AAMC Assembly
Feb. 14 (Sun.)	all day	AMA Congress
Feb. 15 (Mon.)	all day	AMA Congress

VIII. Retreat for Deans of New Schools

The Executive Committee received as information the report from the deans of newly developing schools under Tab Mc of the September 24 meeting. Among other recommendations transmitted by that group was that the "Liaison Committee should consider taking action which would strongly discourage the formation of new two-year medical schools."

IX. Next Meetings

The Executive Committee will next meet on Thursday, October 29, 3:00 - 5:30 pm, Room 2341, Hotel Biltmore, Los Angeles.

The new Executive Committee will meet immediately following the CAS Annual Business Meeting, Saturday, October 31, 5:30 - 6:00 pm, in Dr. Warren's suite at the Biltmore.

X. Adjournment

The meeting was adjourned at 2:30 pm.

[Tab N]

Applications Deferred

1-D. American Academy of Dermatology
2-D. American Academy of Neurology
3-D. American Academy of Physical Medicine & Rehabilitation
4-D. American Association for the Study of Liver Diseases
5-D. American College of Cardiology

6-D. American Society of Plastic & Reconstructive Surgeons, Inc.
7-D. Association for Hospital Medical Education
8-D. Society of Teachers of Family Medicine

1. Name of Society

American Academy of Dermatology

2. Purpose

Annual Meeting most important function of AAD.

3. Membership

4. Number of Members

3, 092 (in 1968)

5.

6. Program of 26th Annual Meeting (held in 1967) available

7. Organized

8. Recommendation - This application was apparently completed in 1968 and apparently rejected because it is a "college."

New information to complete the application at this time has not been requested pending the advice of the Executive Committee.

9. Action

9/24/70 - Executive Committee deferred application
10/10/70 - Executive Committee deferred application

1. Name of Society

American Academy of Neurology

2. Purpose

To stimulate the growth and development of Clinical Neurology by (1) establishing an annual scientific meeting at which clinical and experimental observations on neurological subjects can be presented; (2) establishing a neurological journal for recording clinical and clinically related experimental observations; (3) linking clinical and basic neurological sciences more closely by inviting neurological basic scientists to participate actively in the scientific programs of the Academy; (4) outlining the scope of Clinical Neurology and encouraging recognition of this discipline among the medical profession and in medical schools; (5) establishing a high plane of competence and of clinical value to the literature in Neurology. To stimulate the growth and development of Clinical Neurologists by (1) encouraging the younger members to participate in the scientific and administrative activities of the Academy; (2) encouraging personal relationships and the interchange of ideas between younger Clinical Neurologists and those more senior in the field; (3) encouraging interest among medical graduates to enter Clinical Neurology; (4) furthering personal and scientific contacts between Clinical Neurologists and members of basic neurological fields.

3. Membership

Fellows may be elected only from among physicians (a) who have been certified in Neurology by the American Board of Psychiatrists and Neurologists or by the Royal College of Physicians and Surgeons of Canada and (b) whose chief interest is directed toward practice, teaching, or research in Clinical Neurology; Active members shall be elected from among physicians who have been certified in Neurology by the American Board of Psychiatry and Neurology or by the Royal College of Physicians and Surgeons of Canada.

4. Number of Members

3,382

5. Minutes of the annual business meeting, covering the financial report, committee report, and report from representatives to various committees and councils is available. Date of meeting: April 30, 1970

Copy of the program of the 22nd Annual Meeting of the Academy, April 27-May 2, 1970, is also available.

6. Constitution and bylaws available (included in Membership Directory)

7. Organized

1948

8. Recommendation

9/24/70 - Executive Committee deferred application
10/10/70 - Executive Committee deferred application

1. Name of Society

   American Academy of Physical Medicine and Rehabilitation

2. Purpose

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

3. Membership

   Diplomate of and continued certification by the American Board of Physical Medicine and Rehabilitation.

4. Number of Members

   519 active

5. Constitution and Bylaws available

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

7. Organized

   1938

8. Recommendation - Disapproved 11/69 because it is a college. Another physical medicine society elected at that time.

9. Action

   9/24/70 - Executive Committee deferred application
   10/10/70 - Executive Committee deferred application

1. Name of Society

American Association for the Study of Liver Diseases

2. Purpose

To aid and encourage research in liver diseases, by any means in the Association's power; (b) endeavor to improve methods of diagnosis and treatment of liver diseases; and (c) further the knowledge of liver diseases by seminar discussions of problems pertaining to such diseases.

3. Membership

Any scientist who has contributed to the study of liver diseases, including therein investigators in the various fields of biochemistry, physiology, biology, pathology, experimental medicine as well as clinical investigations.

4. Number of Members

250

5. Constitution and bylaws available

6. Minutes of the 20th Annual Meeting (including agenda), held October 29-30, 1969, are available.

7. Organized

November 3, 1949

8. Recommendation

10/10/70 - Executive Committee deferred application

1. Name of Society

American College of Cardiology

2. Purpose and Membership

Accredited and certified specialists in cardiology and its related disciplines who have as their common objective continuing education and training programs for physicians specializing in diseases of the heart and blood vessels. Such programs provide the College membership with current knowledge and lead to better cardiac patient care and preventive programs in cardiovascular disease. Evident also is the interest in cardiovascular research as it applies directly to the management of the cardiac patient.

3. Number of Members

536

4. Constitution and Bylaws available

5. Minutes Board of Trustees and program of scientific session available.

6. Organized

Chartered and incorporated as a teaching institution under the laws of the District of Columbia on December 2, 1949.

7. Action

9/24/70 - Executive Committee Deferred application
10/10/70 - Executive Committee deferred application

1. Name of Society

   American Society of Plastic and Reconstructive Surgeons, Inc.

2. Purpose

   1. To promote and further medical and surgical training and research pertaining to the study and treatment of congenital and acquired deformities.

   2. To disseminate information regarding clinical and scientific progress of plastic and reconstructive surgery.

3. Membership

   Regularly licensed physicians of plastic and reconstructive surgery, fulfilling the requirements as provided in the Bylaws, may be admitted to membership in this Society.

4. Number of Members

5. Constitution and Bylaws available.

6.

7. Organized

8. Recommendation - Application disapproved 11/68 because (a) other plastic surgery societies are members and (b) this is a "college."

   New information to complete this application has not been requested pending advice of the Executive Council.

9. Action

   9/24/70 - Executive Committee deferred application
   10/10/70 - Executive Committee deferred application

1. Name of Society

   Association for Hospital Medical Education

2. Purpose

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

   This Association exists to accomplish its stated aims by:

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

3. Membership

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

4. Number of Members

   506 active; 200 applications pending

5. Constitution and Bylaws available

6. Programs and minutes of Executive Committee available

7. Organized

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

8. Recommendation - Aggressive drive for membership in 69-70. Application disapproved. Liaison through COTH in discussion.

9. Action

   9/24/70 - Executive Committee deferred application
   10/10/70 - Executive Committee deferred application

1. Name of Society

   Society of Teachers of Family Medicine

2. Purpose

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

3. Membership

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

4. Number of Members

   252

5. Constitution and Bylaws available

6. Minutes of meeting and program available

7. Organized

   October 27, 1967

8. Recommendation -

   10/69 - Executive Committee deferred application
   9/24/70 - Executive Committee deferred application
   10/10/70 - Executive Committee deferred application

Revised 10/20/70

CAS MEMBERS & APPLICATIONS FOR MEMBERSHIP ACCORDING TO DISCIPLINE OR SPECIALTY

AAMC Code		Number of Members
	ALLERGY	
35	*American Academy of Allergy	1869
	ANATOMY	
17	*Association of Anatomy Chairmen	105
2	*American Association of Anatomists	2157
	ANESTHESIA	
29	*Society of Academic Anesthesia Chairmen, Inc.	85
24	*Association of University Anesthetists	98

*CAS Member

AAMC Code		Number of Members
	BIOLOGICAL CHEMISTRY/MICROBIOLOGY	
12	*American Society of Biological Chemists, Inc.	2519

Association of Medical School Microbiology Chairmen
- 4/70 Organization is in development
- 11/70

Academy of Microbiology
- 5/67 Elected
- 6/69 Resigned - CAS programs not relevant

BIOPHYSICS

Biophysical Society
- 5/70 Inquiry
- 6/70 Invited to apply
- 8/70 CAS follow-up

AAMC Code

Number of Members

CANCER EDUCATION

American Association for Cancer Education
12/69 Inquiry and invited to apply
7/70 New inquiry and again invited to apply
8/70 CAS follow-up

CARDIOLOGY

American College of Cardiology
9/24/70 Application deferred
10/10/70 Application deferred

536

Association of University Cardiologists
5/67 Elected
2/68 AUC declined election - budget too small to pay dues

American Heart Association
1/29/71 Inquiry
2/2/71 Invited to complete application

AAMC Code		Number of Members
	CLINICAL RESEARCH	
1	*Academic Clinical Laboratory Physicians & Scientists	223
	American Federation for Clinical Research 10/5/70 Inquiry and invited to apply * 11/12/71 appl Recd	
43	*American Society for Clinical Investigation	452
	Central Society for Clinical Research 2/70 Inquiry discouraged No CAS follow-up	
	Southern Society for Clinical Investigation 10/31/70 To Membership for vote) Tabled by CAS Membership)	165

* Not to be considered in Feb mtgs per AGS -

AAMC Code		Number of Members
	DERMATOLOGY	
20	*Association of Professors of Dermatology	120
	American Academy of Dermatology 9/24/70 Application deferred 10/10/70 Application deferred	3092
	ENDOCRINOLOGY	
45	*The Endocrine Society	1250

AAMC Code		Number of Members
	FAMILY MEDICINE	
	Society of Teachers of Family Medicine	
	10/69 Application deferred	
	9/70 Application deferred	
	10/70 Application deferred	252
	GASTROENTEROLOGY	
42	* American Gastroenterological Association	800
	GYNECOLOGY (See Obstetrics-Gynecology)	

AAMC Code

Number of Members

HISTORY OF MEDICINE

American Association of History of Medicine
5/70 Inquiry
6/70 Invited to complete application
8/70 CAS follow-up

HOSPITAL MEDICAL EDUCATION

Association for Hospital Medical Education
9/24/70 Application deferred
10/10/70 Application deferred

AAMC Code		Number of Members
IMMUNOLOGY		
American Association for Immunologists		
1967-1968	Inquiries	
7/68	CAS last follow-up, no response	
LIVER DISEASES		
American Association for Study of Liver Diseases		
10/10/70	Application deferred	250

AAMC Code		Number of Members
	MEDICINE	
22	*Association of Professors of Medicine	100
16	*Association of American Physicians	250
40	*American College of Physicians	15,000

American Society for Internal Medicine
7/69 Inquiry discouraged pending disposal of application of American College of Surgeons
No further CAS follow-up

AAMC Code		Number of Members
	NEUROLOGY	
25	*Association of University Professors of Neurology	67
9	*American Neurological Association	411
	American Academy of Neurology 9/24/70 Application deferred 10/10/70 Application deferred	3382
	NEUROPATHOLOGY	
5	*American Association of Neuropathologists	351
	NEUROSURGERY	
4	*American Association of Neurological Surgeons	1443

AAMC Code		Number of Members
	OBSTETRICS - GYNECOLOGY	
21	*Association of Professors of Gynecology & Obstetrics	250
39	*American College of Obstetricians & Gynecologists	9243
	American Gynecological Society 5/67 Elected 6/68 Resigned - Education not primary concern of members	
	OPHTHALMOLOGY- OTOLARYNGOLOGY	
26	*Association of University Professors of Ophthalmology	85
36	*American Academy of Ophthalmology & Otolaryngology	9253
	Association for Research in Ophthalmology, Inc. 10/68 Inquiry discouraged because research-oriented	
32	*Society of University Otolaryngologists	78

AAMC Code		Number of Members
	ORTHOPEDICS	
28	*Joint Committee on Orthopaedic Research & Education Seminars	475
	PATHOLOGY	
8	*American Association of Chairmen of Medical School Departments of Pathology, Inc.	110
6	*American Association of Pathologists & Bacteriologists	1094

AAMC Code		Number of Members
	PEDIATRICS	
19	*Association of Medical School Pediatric Department Chairmen, Inc.	118
10	*American Pediatric Society	254
47	*Society for Pediatric Research	383
37	*American Academy of Pediatrics	11,000
	PHARMACOLOGY	
14	*Association for Medical School Pharmacology	117

AAMC Code		Number of Members
	PHYSICAL MEDICINE & REHABILITATION	
15	*Association of Academic Physiatrists	176
	American Academy of Physical Medicine & Rehabilitation 9/24/70 Application deferred 10/10/70 Application deferred	519
	PHYSIOLOGY	
18	*Association of Chairmen of Departments of Physiology	103
11	*American Physiological Society	3286

AAMC Code		Number of Members
	PLASTIC SURGERY	
	*American Association of Plastic Surgeons	100
	American Society of Plastic & Reconstructive Surgeons, Inc. 9/24/70 Application deferred 10/10/70 Application deferred	
46	*Plastic Surgery Research Council	79
	PREVENTIVE MEDICINE	
23	*Association of Teachers of Preventive Medicine	400

AAMC Code		Number of Members
	PSYCHIATRY & PSYCHOLOGY	
3	*American Association of Chairmen of Departments of Psychiatry	94
	American Society of Psychologists in Medical Education 1967 Inquiry discouraged	
	American College of Psychiatrists 5/67 Inquiry 5/67 Application complete 6/67 Referred to credentials committee No follow-up found	
	American Academy of Psychoanalysis 11/68 Inquiry 12/68 CAS response No further correspondence	
	American Psychiatric Association 12/69 Inquiry 9/70 CAS follow-up	
	Orthopsychiatric Association 12/69 Inquiry 9/70 CAS follow-up	
	American Psychosomatic Society 12/69 Inquiry 9/70 CAS follow-up	

AAMC Code		Number of Members
	RADIOLOGY	
30	*Society of Chairmen of Academic Radiology Departments	60
	*Association of University Radiologists	314

AAMC Code		Number of Members
	SURGERY	
30	*Society of Surgical Chairmen	86
33	*Society of University Surgeons	236
13	*American Surgical Association	290
41	*American College of Surgeons	30,000
44	*Association for Academic Surgery	709
	THORACIC SURGERY	
38	* American Association for Thoracic Surgery	400
	UROLOGY	
34	*Society of University Urologists	156

[Tab O]

The Activities of the Association of American Medical Colleges Supporting Biomedical Research

The Association of American Medical Colleges, through its Councils' leaders and its staff, clearly represent all aspects of the academic institutions of this country concerned with biomedical research, education and service. Within the Councils, experts with great national prestige are identified and their talents utilized in furthering public support for health and health research. The council of Academic Societies, because its representatives are drawn from academic societies concerned with basic and clinical sciences, provides a unique resource for promoting research and research training interests.

The membership and professional staff of the AAMC are frequently called upon to provide advice and guidance to both the Executive and Legislative branches of the Government. In many instances this advice is sought on an informal basis, and in other instances on a formal basis, through service on advisory committees and councils and through testimony before Congress. The Association also takes the initiative in promoting programs which will provide more adequate funding for biomedical research and education. Through these activities, the Association has developed an increasingly active and positive role in attempting to increase the level of support for biomedical research and research training.

By providing a balanced view of the problems in academic medical centers, the Association has been able to speak forcibly on the importance of improving research support at a time when governmental interests and public pressure have shifted toward education and service.

During the past two years, the AAMC has provided testimony before Congressional committees on every occasion in which legislation affecting the activities of the academic medical centers in research, education and service was being considered. Testimony stating the AAMC's position on important legislation related to biomedical research is exemplified by Dr. John A. D. Cooper's recent appearance before the Senate Subcommittee on Health regarding a bill which would establish a National Cancer Authority outside the NIH. That testimony emphasized that the state of our scientific knowledge about the fundamental causes of neoplasia did not warrant an authority separate from the NIH-NCI. The importance of increasing research support through the NIH for both specific, targeted programs and for the broad support of basic research was stressed. The great productivity of NIH-administered research in the past was pointed out in justifying the AAMC position that the several Institutes were the best agencies through which to expend money for cancer research.

In the question-and-answer interchange with Senator Kennedy, Dr. Cooper emphasized that the cut-back in funding for training grants will seriously diminish the availability

of young scientists upon whom a major expansion of research related to cancer is critically dependent.

Testimony before appropriations committees has been important, and the AAMC has consistently requested more funds for research than were budgeted by the administration. Attached is a copy of a portion of Dr. Cooper's testimony before the Labor-HEW Subcommittee of the Senate Appropriations Committee in June 1970 relating to research and research training.

In 1970 the health appropriations bill reported out of the House Committee was seriously inadequate. The AAMC worked closely with and provided data to concerned Congressmen sponsoring a floor amendment to increase the appropriation. The debate on the amendment consumed a week; and though it ultimately was defeated, this effort clearly indicated that appropriations for health and health research could not be lightly considered by the Congress. Later, this focused greater attention on health appropriations in the Senate during the 1970 session. Now, during the 1971 session, last year's effort to introduce an appropriations amendment is having a detectable effect upon the attention of the Congress to health and health research needs.

Last year the Association participated in a Coalition for Full Funding and this year took the leadership in bringing together many voluntary agencies concerned with health and health-research appropriations. The Coalition for Health will be announced in Washington May 4, 1971. Members of the

House and Senate and interested health organizations will be present to urge increased support for NIH and HSMHA. This formation of a Coalition is an important strategy. Through presenting a united front, support for funding the Federal commitment to health and health research can be mobilized as a single force, thus avoiding each group's narrowly speaking for itself. A copy of the health budget recommended by the Coalition is attached.

Several categories recommended for FY'72 should be noted. (1) The recommendation for the NIH Institutes is $232 million over the President's budget. The increased funding requested will provide for the 1969 level of project grant research and research training support increased by 6% a year compounded to take into account inflation. The Association maintains that the research training grants should be continued in their present format and that allocations for faculty salaries should be permitted on research and research training grants. (2) The National Library of Medicine recommendation is $3.5 million over the President's budget. (3) The Mental Health Research recommendation is $16 million over the President's budget. These major increases are being requested during the administration of an Executive branch which has little inclination to allocate such large resources to research. While full acceptance of the Coalition's figures by Congress is not likely, it can be expected that the final appropriations will be considerably greater than the admimistration's figures.

Good, supportive, informal relationships have developed between the AAMC and key Congressional committees responsible for legislation related to medical education and medical research. The AAMC staff is frequently consulted by Congress regarding specific legislative language. Congressional committees also meet informally with the AAMC leadership and staff to be briefed about problems and needs of the medical schools and the maintenance and development of their educational and research programs.

The Association staff is in frequent contact with various departments of the Government responsible for administering biomedical research- and education-support programs. In meetings with Secretary Richardson and Assistant Secretary Egeberg of the Department of Health, Education and Welfare, the AAMC staff and top leaders have taken a strong position regarding the importance of biomedical research and research training to the Nation's health and welfare.

Both Dr. Cooper and Mr. Joseph S. Murtaugh, Director of Planning and Policy Development, have been called upon to advise the Office of Science and Technology. Questions regarding research support and support of research training have been especially addressed. The tragic consequences to the Nation's goals caused by a decline in the vitality of biomedical research are repeatedly emphasized. The importance of the continuous development of vigorous, young researchers with new ideas has been stressed.

As a member of three advisory committees of the Office of Scientific Manpower in the National Academy of Sciences-National Research Council, Dr. Cooper has been involved in the development of policy by NAS-NRC on graduate education. He chaired a Committee on the Study of Research Training Grant Programs which made a detailed survey of training grants, developed convincing data on their effectiveness and recommended they not only be continued in their present form, but doubled in size. The Committee findings were published by the Department of Health, Education and Welfare under the title, "Effects of NIGMS Training Programs on Graduate Education in the Biomedical Sciences".

The many activities outlined above have been carried out during a period when the AAMC was reorganizing and moving its offices to Washington, D.C.

It must be kept in mind that during this same period, changes in National leadership have resulted in declining Federal administrative interest in supporting progressive developments in research generally as well as the biomedical sciences. How much the Congress might have increased the inadequate Presidential recommendations for research without the impetus of AAMC testimony to its committees and AAMC furtherance of a floor amendment to the appropriations bill in 1970 cannot be ascertained precisely. Similarly, the impact of the AAMC effort to modify DHEW, OST, NAS-NRC conceptions of the importance of medical research and research training programs in our medical schools cannot be clearly assessed.

In both instances it is likely that if there had been no input from the AAMC, the research endeavors of our faculties and students would be even more seriously crippled than at present.

The report of the ad hoc Biomedical Research Policy Committee of the Council of Academic Societies will shortly be sent to the representatives and officers of the member societies of the Council and will be published in the August issue of the JOURNAL OF MEDICAL EDUCATION. This excellent report strongly recommends that an organizational framework be established within the AAMC which is capable of interpreting to the Federal Government and the public the past and potential contributions of biomedical research to the Nation's health and welfare. This recommendation has been accepted by the Executive Council of the Association.

Developing effective capability in this area will require the recruitment of talented, knowledgeable staff leadership and the development of strategies for information collection and dissemination which will be able to respond to the ever-changing attitudinal climate in the academic medical centers, the Federal Government and the public. Recruitment of additional staff to make it possible to further extend the AAMC's capabilities is in progress.

Meanwhile, AAMC efforts to prevent disruption of biomedical research programs will continue through working with both the Legislative and Executive branches of the Federal Government.

Portion of Dr. Cooper's testimony before the Labor-HEW Subcommittee of the Senate Appropriations Committee in June 1970.

SUPPORT OF MEDICAL RESEARCH AND TRAINING

Our academic medical centers are the single most important source of research activity and research information in medicine and the life sciences. The great progress in medicine that we have witnessed in our lifetime has been the direct consequence of the expanded scientific effort to discover the nature of disease and decipher the mystery of life. These advances have transformed our overall prospects for health and radically changed the character and quality of medical care and health services. Telling examples of the effects upon life-expectancy and health service demands made possible by the quiet advances of research are many.

The nation is now involved in major spending of substantial sums to care for people, especially children, suffering from mental retardation and

other crippling congenital defects as a consequence of German measles. This should be viewed against the new possibility for the eventual total elimination of this health burden through the widespread use of newly developed vaccine against the German measles virus. The scientific knowledge that has made possible the successful development of this vaccine was accumulated over fifteen years in programs of wide-ranging fundamental research on the nature of viruses, the genetics of viruses, and the means to propagate them safely in the large quantities needed for vaccine production.

Similarly, Parkinson's disease, a progressive disabling disorder of the nervous system, long has made enormous demands upon the nation's health facilities and health personnel to provide the long-term nursing and domiciliary care required for thousands of victims of this disease. Federally supported research has now shown that the drug L-dopa is highly effective in controlling the debilitating manifestations of Parkinsonism. As a consequence many who suffer from this affliction will now become self-reliant and will be able to return to near normal activity, greatly relieving the need to care for them as invalids.

Beyond these examples, there is a long list of crippling diseases whose care under presently available knowledge and technology consumes a substantial portion of the nation's health expenditures because they afflict such a large proportion of the population. Included amongst these is rheumatoid arthritis, which, although now explicable under a newly developed viral theory that may one day lead to a preventive vaccine, continues to afflict better than 10 million people in the United States; diabetes mellitus, commonly referred to as diabetes, with approximately 5 million cases in the United States; and arteriosclerosis, a slow but sure killer of which there may be more than 50 million cases in the United States. In addition to their

high cost, these diseases cause untold human misery and sorrow and kill off highly productive people in their prime.

The considerable dimensions of the essentially unnecessary and potentially controllable incidence of disease, disability, and death with which we must now contend is reflected by the fact that:

...people under the age of 65 comprise two-thirds of all short-term acute hospital patient days

...on any given day, an average of 1,684,000 people in the nation's employed labor force are absent because of illness

...44% of the entire population of the United States suffer from some chronic condition that imposes some degree of disability

...50% of all deaths are below age 70 --- the Biblically alloted life span.

Medical ability to prevent, treat or cure these diseases altogether, is seriously impaired for want of any useful explanation of their cause or development.

Thus, our chief hope of halting the rising costs of medical care, diminishing the burden of illness or disability and forestalling premature death, lies in continued and substantial programs of medical research. Only through the acquisition of new knowledge and its application in more sophisticated technology, can we hope to deal effectively with all aspects --- prophylactic, diagnostic and therapeutic --- of disease.

Government support for the scientific exploration of disease during the past two decades has brought us to the threshold of an era of unparalleled potential for biomedical research. From 1955 to 1967,

largely through the programs of the National Institutes of Health, increasing annual commitments of Federal funds for research, education of biomedical scientists, and construction of research facilities made it possible for American universities and medical schools to broaden the scientific base for preventive and therapeutic medicine. The United States assumed undisputed leadership in biomedical and health research, evolving a system which was to become a paradigm for the entire world.

In order to retain that position of leadership we must endeavor to preserve the structural and procedural devices which have made that leadership possible. It would therefore be sheer folly in our otherwise commendable efforts to translate long-term research gains into immediate health care benefits, to sacrifice by way of trade-off, the integrity of our biomedical research establishment. Unfortunately, the current parsimonious trend in budgeting for Federal health programs more than suggests the grave possibility that this nation's continued investment in the long-term advancement of the scientific base of medicine and health may be progressively dismantled.

In the five-year period 1965 through 1969, the total national expenditure, public and private, for medical care and health purposes increased from $38,900,000,000 to $63,000,000,000. The Federal share of this expenditure rose from $4.6 billion to $15.1 billion, an increase of over 330 percent. During this period of rapidly increasing health service expenditures, the nation's investment in medical research increased only 40 percent, from $1.8 billion in 1965 to $2.6 billion in 1969.

In proportion to total health expenditures, medical-research spending actually declined from a level of 5 percent in 1965 to barely 4 percent in

1969. Federal medical research expenditures, as a proportion of total Federal health expenditures, dropped from 24 percent to 11 percent in the same period.

This cutback in support for biomedical research was continued in the appropriations for Fiscal Year 1970 and is implicit in the President's request for Fiscal Year 1971. What is clearly overlooked in the budgetary planning which generated these figures, is the effect of wage-price inflation which has been conservatively estimated to be increasing at a rate of 6 percent per annum. The effects of this inflationary factor on funding for medical research is reflected in the following comparison between the budget levels proposed for the research programs of the National Institutes of Health and in Fiscal Year 1969, 1970, and 1971 with the amounts required to maintain the 1969 program level under a 6 percent wage-price increase:

	President's Budget	Requirement to Maintain 1969 level of Research Activity	Deficit in Budget Allowances
Fiscal Year 1969	$1,002,537		
Fiscal Year 1970	973,749	$1,062,689	$ 88,940
Fiscal Year 1971	1,035,548	1,190,351	154,803

For Fiscal Year 1971, the figures include in addition to the inflationary allowance, the special programs increases proposed.

Beyond the failure to offset the function of inflation in substantially reducing the actual level of these vital research programs, the appropriation request for Fiscal Year 1971 now before the Subcommittee will have other unfortunate effects:

1. The General Research Support Program will be cut back by $12 million. If this cut is allowed to stand, it will result in the major erosion of a program which for almost 10 years has constituted the single most important

source of institutional funds for the development and fortification of graduate research and educational programs along those lines best suited to each institution's particular needs and capabilities. This program has been the sine qua non for advancing the overall stability of the research and research training programs of our nation's medical schools and the proposed cut-back would be a dangerously retrogressive step in Federal university support policies.

2. The Administration budget porposes further reductions in the Fellowship and Training Grant Programs of NIH. These programs are the major sources of support for graduate and post-doctoral training in the medical sciences. The individuals trained under these programs form the first manpower pool from which the research investigators, education leaders, and clinical faculty needed to staff the new and expanded medical schools and their institutional counterparts in the other health professions must be drawn. Consequently, these cuts conflict directly with the efforts that would be undertaken under other programs supported in this bill to increase health manpower.

3. For the second year in a row, the President's budget makes no provision for the construction of research facilities. This program together with the research training programs of the NIH represents our investment in the nation's future medical capability. If we are to reap the promise of the progress we have made in the medical sciences thus far, we must continue the expansion of the basic resources required to insure further progress. Cessation of research-facility construction will effectively halt the further growth of medical research in this nation because the need for new and expanded research space as well as the repair and renovation of existing space are at a critical stage. A recent nation-

wide study of the existing medical-research plant of the nation shows that to carry out urgently needed repairs and renovations, to relieve overcrowded facilities, and to assure proper housing of research animals, an addition of 14.8 million net square feet of space is required, estimated to cost $1.7 billion. This is to provide for our existing research programs without any provision for future expansion. Last year, and now this year under the President's budget, no new funds are available for this most essential program.

Thus in summary, the cumulative results of the abrupt slackening of financial support for biomedical research and training that commenced four years ago and the steady erosion of the system by inflation are becoming alarmingly evident:

...ongoing research programs of high quality and demonstrated merit have been curtailed; some are now threatened with termination by lack of funds

...teams of scientists and technicians painstakingly organized over many years are being disbanded as their productivity is hampered by fiscal stringency

...younger scientists are finding increasing difficulty in obtaining support for exploration of exciting new areas of great promise

...training and educational programs, the vital sources of the academic cadre required to meet the nation's urgent and growing needs for more health professionals, are faltering; some have been forced to shut down completely because the support which brought them into existence has dropped below the point that

enables them to remain viable and productive

...the vital base of medical education and research, which are indisputably symbiotic, is threatened with a growing instability dangerous to the continued operation of many schools

...highly significant alternative approaches to the control of important diseases remain unexplored simply because there are no funds to sustain forward movement.

It would be tragic and at the very least ironic, if we were to allow this nation's long-standing and highly productive investment in medical research to dissipate by default and neglect at precisely that moment in history when our governmental commitment to the health care of the country's children, aged citizens, and disadvantaged groups is finally being nailed down and translated into ever-widening programs. How can the better delivery of health care to these groups especially, constitute anything like a medical "Bill of Rights" if that health care proceeds in the absence of the latest scientific knowledge? And what is the source of that knowledge, if not research? It is particularly ironic that it is this very commitment to health services that is offered as the reason for limiting budgets for health research. The educational and scientific lead times for improving health care are long, and false economy today can lead to the deterioration of our capability to cope with the problems of tomorrow.

We therefore urge the Committee to recommend that the appropriations for the Research Institutes and Divisions of the National Institutes of Health be increased by the amounts necessary to offset the 6 percent annual increase in price and wage costs over the Fiscal Year 1969 base. In doing so, we do not mean to imply that the 1969 figures were by any means optimal, but they at least represent the last consensus of legislature

and executive on those levels of support which, in the context of a war-time economy and a severe inflation, could be justified as not incompatible with the survival of our biomedical research establishment. I might add here that the Association of American Medical Colleges has recently established a Biomedical Research Policy Committee under its Council of Academic Societies. This Committee is embarking on a thorough study of the question of the appropriate levels of support for biomedical research in this country. Through this means, we hope to provide a more rational basis for the development of national policy in respect to the support of the biomedical sciences. We shall be pleased to present the results of this examination to this Subcommittee when the study is completed.

In addition to an increase of 6 percent in the basic programs, we would like to see preserved intact the Administration-recommended increases over 1970 for the special emphasis research programs in the selected disease and health problems areas, which hold the promise of immediate advance in our capability to manage them, i.e., major breakthroughs in the conquest of disease and disability. The Administration has very wisely singled out these programs for special fiscal support through additional funding.

We urge also that the General Research Support Programs be continued at a full funding level, meaning the same 6 percent annual increment, and that the full authorization of $30 million be appropriated for the Health Research Facility Construction program under Section 704 of the Public Health Service Act.

APPROPRIATIONS FOR THE NATIONAL INSTITUTES OF HEALTH
(In Thousands of Dollars)

NIH PROGRAMS	ACTUAL APPROPRIATION FY 1969	FY 1970	FY 1971*	PRESIDENT'S BUDGET FY 1972 AMOUNT	CHANGE FROM FY 1971	RECOMMENDATIONS OF COALITION FOR HEALTH** AMOUNT	INCREASE OVER PRES'S BUDGET
RESEARCH INSTITUTES							
Biological Standards	8,499	8,237	9,127	8,636	-491	8,636	--
National Cancer Institute	185,150	181,357	232,234	232,234	--	239,934	7,70
National Heart and Lung Institute	166,928	160,549	194,448	194,448	--	238,800	44,35
National Institute of Dental Research	29,984	28,744	35,631	38,400	2,769	43,600	5,20
National Institute of Arthritis and Metabolic Diseases	143,888	131,678	139,324	134,400	-4,924	166,700	32,30
National Institute of Neurological Diseases & Stroke	128,935	97,265	106,651	95,496	-11,155	120,996	25,50
National Institute of Allergy & Infectious Diseases	96,840	97,290	103,062	98,431	-4,631	112,031	13,60
National Institute of General Medical Sciences	163,513	148,209	166,322	150,091	-16,231	196,391	46,30
National Institute of Child Health & Human Development	73,126	76,058	95,035	102,532	7,497	153,632	47,46
National Eye Institute	--	22,814	31,095	32,434	1,339	32,434	--
National Institute of Environmental Health Sciences	17,820	17,418	20,805	25,039	4,234	26,339	1,30
Research Resources	84,809	67,039	66,276	67,916	1,640	76,216	8,30
John E. Fogarty International Center for Advanced Study in the Health Sciences	600	2,775	3,636	3,252	-384	3,252	--
Special Cancer Research Initiative	--	--	--	100,000	100,000	100,000	--
TOTAL RESEARCH	$ 1,000,092	$ 1,039,433	$ 1,203,646	$ 1,283,309	$ 79,663	$ 1,518,961	$ 232,02
HEALTH MANPOWER							
Medical, dental and related health professions:							
(a) Institutional support	$ 76,224	$ 112,224	$ 124,069	$ 271,650	$ 147,581	$ 570,000	$ 298,35
(b) Student assistance							
(1) Direct loans	15,000	15,000	25,000	22,027	-2,973	60,000	37,97
(2) Scholarships	11,219	15,541	15,500	15,500	--	29,000	13,50
(c) Construction	76,800	118,100	131,600	96,700	-34,900	300,000	203,30
(d) Educational grants & contracts & direct operations	--	--	14,741	15,671	930	15,671	--
(e) Health research facilities	8,400	--	--	--	--	30,000	30,00
Subtotal	187,643	260,865	310,910	421,548	110,638	1,004,671	583,12
Nursing:							
(a) Institutional support	7,000	7,000	11,500	11,500	--	295,000	283,50
(b) Student assistance							
(1) Direct loans	9,610	9,610	17,110	9,610	-7,500	25,000	15,39
(2) Scholarships	6,500	7,178	17,000	17,000	--	25,000	8,00
(3) Traineeships	11,120	11,120	10,470	11,470	1,000	20,000	8,53
(c) Construction	8,000	8,000	9,500	8,000	-1,500	40,000	32,00
(d) Educational grants & contracts & direct operations	--	--	9,131	10,438	1,307	17,500	7,06
Subtotal	42,230	42,908	74,711	68,018	-6,693	422,500	354,48
Public health:							
(a) Institutional support	9,471	9,471	9,571	9,571	--	27,000	17,42
(b) Traineeships	8,000	8,000	8,400	8,400	--	16,000	7,60
(c) Direct operations	--	--	504	543	39	543	--
Subtotal	17,471	17,471	18,475	18,514	39	43,543	25,02
Allied health:							
(a) Institutional support	10,975	10,988	9,750	10,000	250	20,000	10,00
(b) Traineeships	1,550	1,550	3,750	3,750	--	6,500	2,75
(c) Construction	--	--	--	--	--	30,000	30,00
(d) Educational grants & contracts & direct operations	--	--	5,986	12,744	6,758	12,744	--
Subtotal	12,525	12,538	19,486	26,494	7,008	69,244	42,75
Manpower Requirements and Utilization	15,731	16,746	--	--	--	--	--
Program Direction and Manpower Analysis	--	--	5,159	6,227	1,068	6,227	--
TOTAL HEALTH MANPOWER	$ 275,600	$ 343,914	$ 428,741	$ 540,801	$ 112,060	$ 1,545,185	$ 1,005,38
NATIONAL LIBRARY OF MEDICINE	$ 18,160	$ 19,142	$ 21,207	$ 21,486	$ 279	$ 25,000	$ 3,51
BUILDINGS AND FACILITIES	--	1,615	--	3,325	3,325	3,325	--
OFFICE OF THE DIRECTOR	--	8,037	8,667	11,083	2,416	11,083	--
SCIENTIFIC ACTIVITIES OVERSEAS (Special foreign currency program)	--	3,455	28,944	25,545	-3,399	25,545	--
HEALTH EDUCATION LOANS Amount of sales insufficiencies and interest losses	200	2,693	3,083	4,000	917	4,000	--
GRAND TOTAL, NIH	$ 1,394,052	$ 1,419,289	$ 1,694,288	$ 1,889,549	$ 195,261	$ 1,141,099	$ 1,253,51

*Includes $9.3 million for pay increases to be provided by supplemental appropriation.
**AAMC Recommendations for Research: FY 1969 are compounded to FY 1972 at 6% per year plus the $100 million for special cancer initiative; for Manpower items based on authorizations proposed in HR 4171.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

1972 BUDGET ESTIMATES
From Budget of U.S. Gov't Appendix
(In Thousands of Dollars)

Revised

MENTAL HEALTH - PROGRAM AND ACTIVITIES:	1969 $	1970 $	1971 $	1972 $	Difference 1972 Compared To 1971 $	Recommendations of Coalition for Health: Amount $	Recommendations of Coalition for Health: Change from '72 Budget $
1. Research:							
(a) Grants	91,630	84,796	90,600	92,400	1,800	109,131	16,731
(b) Direct Operations	22,589	26,797	26,426	26,942	516	26,942	--
Subtotal	114,219	111,593	117,026	119,342	2,316	136,073	16,731
2. Manpower Development:							
(a) Grants	119,648	118,335	116,350	113,300	-3,050	157,000	43,700
(b) Direct Operations	2,971	5,678	5,810	5,765	-45	5,765	--
Subtotal	122,619	124,013	122,160	119,065	-3,095	162,765	43,700
3. State and Community Assistance:							
(a) Community Mental Health Centers							
(1) Construction	27,086	23,995	27,678	--	-27,678	45,000	45,000
(2) Staffing	42,732	47,622	90,100	105,100	15,000	170,100	65,000
(b) Narcotic Addiction and Alcoholism Programs	8,000	3,057	29,713	40,193	10,470	224,000	183,807
(c) Direct Operations	2,232	2,715	3,431	3,938	507	3,938	--
Subtotal	67,964	77,389	150,922	149,231	-1,691	443,038	293,807
4. Rehabilitation of Drug Abusers	14,414	17,131	20,308	20,611	303	20,611	--
5. Program Support	9,531	12,234	13,694	13,983	289	13,983	--
Total, Mental Health	328,747	342,360	424,110	422,232	-1,878	776,470	354,238
Change in Selected Resources		-1,096	--	--	--	--	--
Adjustments	--	12,952	-36,006	-160	-1,878	--	160
New Obligational Authority	328,747	354,216	388,104	422,072	33,968	776,470	354,398
ST. ELIZABETHS HOSPITAL:							
New Obligational Authority	39,482	16,883	21,966	21,291	-675	21,291	--
HEALTH SERVICES RESEARCH & DEVELOPMENT:							
New Obligational Authority	40,922	42,593	57,626	61,484	3,798	82,000	20,516
COMPREHENSIVE HEALTH PLANNING SERVICES:							
Partnership for Health	171,132	183,155	228,041	229,091	1,050	341,572	112,481
Migrant Health	8,100	4,518	15,041	18,056	3,015	25,000	6,944
Med Stds & Implementation	--	5,790	6,553	6,736	183	6,736	--
Prog Direction & Mgmt Services	7,877	2,394	2,493	2,373	-120	2,373	--
Emergency Health Corps	--	--	--	--	--	20,000	20,000
Adjustments	--	10,030	-4,519	-4,519	--	--	4,519
Total	187,109	205,887	247,609	251,737	4,128	395,681	143,944
MATERNAL AND CHILD HEALTH:							
Grants to States		107,856	117,850	119,650	1,800	158,250	38,600
Project Grants		75,825	83,350	90,380	7,030	130,000	39,620
Research and Training	(N O T	14,885	16,935	21,106	4,171	32,250	11,144
Prog Direction and Mgmt Services			4,166	4,299	133	4,500	201

	AVAIL-						
FAMILY PLANNING ACTIVITIES:							
Grants and Contracts	ABLE)	22,800	31,765	88,815	57,050	88,815	--
Direct Operations		--	1,804	2,122	318	2,122	--
Child Welfare		56,328	--	--	--	--	--
Adjustments	--	209	--	--	--	--	--
Total	208,027	277,903	255,870	326,372	70,502	415,937	89,565
REGIONAL MEDICAL PROGRAMS:							
New Obligational Authority	83,206	96,586	106,809	52,456	-54,353	118,000	65,544
COMMUNICABLE DISEASE CONTROL:							
Prevention & Control	(NOT	36,301	37,412	36,970	-442	97,700	60,730
Laboratory Management		6,627	7,211	7,343	132	7,343	--
Occupational Health	AVAIL-	--	--	16,465	16,465	16,465	--
Radiological Health		--	--	11,226	11,226	11,226	--
Community Environment Management	ABLE)	--	--	3,699	3,699	24,831	21,132
Program Direction Management		2,173	2,323	2,340	17	2,340	--
Adjustments	--	-3,247	-1,149	--	1,149	--	--
New Obligational Authority	69,430	41,882	45,797	78,043	32,246	159,905	81,862
MEDICAL FACILITIES CONSTRUCTION:							
(1) Construction Grants	254,466	200,576	170,212	58,280	-111,932	172,200	113,920
(2) Direct Loans	--	--	30,000	30,000	--	30,000	--
(3) Interest Subsidies	--	--	4,700	20,600	15,900	20,600	--
(4) D.C. Medical Facilities	15,000	11,337	19,365	7,000	-12,365	7,000	--
(5) Prog Direction and Teaching Assistance	3,497	3,662	3,314	3,395	81	3,395	--
Total Program Costs Funded	272,963	215,575	227,591	119,275	-108,316	233,195	113,920
Changes in Selected Resources		55,557	--	--	--	--	--
Adjustments	--	-91,439	-42,306	-10,580	31,726	--	10,580
New Obligational Authority	272,963	179,693	185,285	108,695	-76,590	233,195	124,500
Loan Authority	--	5,000	40,000	30,000	-10,000	30,000	--
PATIENT CARE AND SPECIAL HEALTH SERVICES:							
Hospital Operating Costs						100,000	
Modernization Funds	(NOT AVAILABLE)					36,000	
Study of Broadening Patient Coverage						10,000	
Total	70,394	79,116	84,093	69,979	-14,114	146,000	76,021
NATIONAL HEALTH STATISTICS:							
New Obligational Authority	8,028	9,366	10,115	15,253	5,138	15,253	--
INDIAN HEALTH SERVICES & FACILITIES:							
New Obligational Authority	112,792	118,502	133,608	156,365	15,756	156,365	--
OTHER, INTERNAL OPERATIONS:							
New Obligational Authority	33,458	41,602	42,158	39,015	3,858	39,015	--
TOTAL HSMHA -							
New Obligational Authority	$ 1,183,596	$ 1,464,229	$ 1,579,040	$ 1,602,702	$ 23,662	$ 2,589,112	$ 956,350

4/9/71 - DOS

[Tab P]

Possible Schedules for Dues for Member Academic Societies

Each of these schedules is based upon a capitation rate per member. In each instance a minimum and a maximum amount for a society is stipulated. Variable per society costs are provided for those societies falling between the minimum and maximum amounts.

Schedule #1

Minimum

Societies with less than 200 members - $200.00

Maximum

Societies with more than 5,000 members - $5,000.00

Variable

Societies with 200 - 5,000 members - $1.00/member

Approximate yield - $47,500

Schedule #2

Minimum

Societies with less than 100 members - $200.00

Maximum

Societies with more than 2,500 members - $5,000.00

Variable

Societies with 100 - 2,500 members - $2.00/member

Approximate yield - $65,000

Schedule #3

Minimum

Societies with less than 100 members - $200.00

Maximum

Societies with more than 5,000 members - $10,000

Variable

Societies with 100 - 5,000 members - $2.00/member

Approximate yield - $91,000

COUNCIL OF ACADEMIC SOCIETIES

Members

Professorial Societies	Number of Members
Academic Clinical Laboratory Physicians and Scientists	75
American Association of Chairmen of Departments of Psychiatry	96
American Association of University Professors of Pathology	100
Association for Medical School Pharmacology	90
Association of Academic Physiatrists	176
Association of Anatomy Chairmen	90
Association of Chairmen of Departments of Physiology	91
Association of Medical School Pediatric Department Chairmen, Inc.	115
Association of Professors of Dermatology	120
Association of Professors of Gynecology & Obstetrics	250
Association of Professors of Medicine	81
Association of Teachers of Preventive Medicine	400
Association of University Professors of Neurology	67
Association of University Professors of Ophthalmology	81
Joint Committee on Orthopaedic Research & Education Seminars	230
Society of Academic Anesthesia Chairmen, Inc.	135
Society of Chairmen of Academic Radiology Departments	60
Society of Surgical Chairmen	86
Society of University Otolaryngologists	78
Society of University Urologists	60

Professional Societies	Number of Members
American Association of Anatomists	2039
American Association of Neurological Surgeons	1134
American Association of Neuropathologists	351
American Association of Pathologists and Bacteriologists	1025
American Association of Plastic Surgeons	150
American Neurological Association	411
American Pediatric Society	254
American Physiological Society	3006
American Society of Biological Chemists, Inc.	2307
American Surgical Association	290
Association of American Physicians	250
Association of University Anesthetists	108
Association of University Radiologists	215
Society of University Surgeons	500

New Members	No. of Members
American Academy of Allergy	1,869
American Academy of Ophthalmology & Otolaryngology	9,253
American Academy of Pediatrics	11,000
American Association for Thoracic Surgery	400
American College of Obstetricians & Gynecologists	9,243
American College of Physicians	15,000
American College of Surgeons	30,000
American Gastroenterological Association	800
American Society for Clinical Investigation	452
Association for Academic Surgery	709
Endocrine Society	1,250
Plastic Surgery Research Council	79
Society for Pediatric Research	383
TOTAL MEMBERSHIP TO CAS	94,959